DEPA	RIMENT OF HEALTH	HAND HUMAN SERVICES				PRINT	ED: 10/09/200
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES		•	6tm	FO	RM APPROVE
I STATEME!	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ	IULTIPLE CO	ONSTRUCTION OO	(X3) DAT	NO. 0938-039 E SURVEY IPLETED
		085012				7 4 2009 0	•
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	<del></del>	Uhotor	<u> </u>	7/25/2009
	CY HEALTHCARE & R	EHAB CENTER			DIRECTOR STATE, ZING PROOM STREET IGTON, DE 19806	<sup>XO</sup> IIIco	
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F 000	INITIAL COMMENT	S	F0	00		<u> </u>	
	F225 was deleted. F severity from a G to	248 change in scope and a D, some text changes age in scope and severity					
F 174	conducted at this facthrough July 25, 200 contained in this repinterview, review of review of other docufacility census the fir The survey sample to	ort are based on observation, lesidents' clinical records and mentation as indicated. The st day of the survey was 98 otaled 107 residents, which esidents, 30 admission ge 2 residents.	F 17	4			9/4/09
SS=E	The resident has the access to the use of be made without being.  This REQUIREMENT by: Based on observation interviews, and review was determined that residents phone accedalls can be made with Findings include:  1. During interviews of 7/23/09 at 12:30 PM, does not have privacy He stated that he has	right to have reasonable a telephone where calls can ng overheard.  T is not met as evidenced		F174		d location of 24 cordless phone esident Council e cordless in the business lar business e facility nursing evening and inistrator cial Service with R91 ove information.	g
La	statement ending with an	Jethnan RN, M	15		NHA	10/	14/09
CONLIENCY	aratement ending with an	geteriek (*) donotoe o deficie *	Attack to a second	, .		1	,

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued participation.

INTERLETATION OF FORRECTION  (X1) PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  (X2) MULTIPLE CONSTRUCTION  A BUILDING  3. WING  (X3) DATE SURVEY COMPLETED  (X4) DATE SURVEY COMPLETED  (X5) DATE SURVEY COMPLETED  (X6) PREDICTED  (X			I AND HUMAN SERVICES	1 (2. VIII) 19	SARY!	productive and the second of t		APPROVED 0938-0391
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E2, and the Administrator, E1, stated that residents can purchase telephone service for \$16.00/month or they could use any of the offices or the nurses' desk. and that there is a "portable phone" in the building that they could use They added that they believed that (E9) from admissions even goes over that with the families during the admissions process.  Interview with E9 in the Admissions Office stated that there are no longer free phones residents can bring their own phones and pay \$16.00/month or if they can't afford one, there is a portable phone in the front office. A copy of the		pitvaic.			-			
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families during the admissions process.  Interview with E9 in the Admissions Office stated that there are no longer free phones residents can bring their own phones and pay \$16.00/month or if they can't afford one, there is a portable phone in the front office. A copy of the  monitored through Resident Council meetings to ensure residents have access to phone and to determine if there are any staff education/in-servicing needs, and will be monitored through and records maintained by Staff								
Interview with E9 in the Admissions Office stated that there are no longer free phones residents can bring their own phones and pay \$16.00/month or if they can't afford one, there is a portable phone in the front office. A copy of the								
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that there are no longer free phones residents can bring their own phones and pay \$16.00/month or if they can't afford one, there is a portable phone in the front office. A copy of the  staff education/in-servicing needs, and will be monitored through and records maintained by Staff		Interview with E9 in	the Admissions Office stated	!				
can bring their own phones and pay \$16.00/month or if they can't afford one, there is a portable phone in the front office. A copy of the phone in the front office of the phone in the front office. A copy of the phone in the front office of the phone in the front office. A copy of the phone in the front office of the phone in the front office. A copy of the phone in the front office of the phone in the front office of the phone in the front office.	-							
\$16.00/month or if they can't afford one, there is a portable phone in the front office. A copy of the phone in the front office. A copy of the provided the copy of the copy of the copy of the provided the copy of the copy o				1				
portable phone in the front office. A copy of the records maintained by Starr	• .							·
phone Admission Agreement entitled, "Regency Educator through in-Servicing at						Educator through in-sei	vicing at	
Healthcare Telephone Service" was provided. hire and August 2009 facility wide				1.			acility wide	
in-service.		10.00		1		in-service.		
Review of this phone admission agreement		Review of this phor	ne admission agreement					1
stated, "Each resident must provide their own								
				<u> </u>				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION	i .	(X3) DATE S COMPLE	
		000040	B. WII				•
		085012			· · · · · · · · · · · · · · · · · · ·	07/2	5/2009
	PROVIDER OR SUPPLIER  CY HEALTHCARE & F	REHAB CENTER		STREET ADDRESS, CITY 801 N. BROOM STRI WILMINGTON, DE	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X EACH CORF	R'S PLAN OF CORRECT SECTIVE ACTION SHOW THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 174	Continued From pa	age 2	F.	74			
	phone there w business office dur use. The nursing s portable phone at r. Review of the facili listed under Reside "The resident has t access to the use obe made without be Telephones in staff do not meet the pro Accommodations telephones, having rooms 2 At least installed on each miresidents on wheeled be installed in the relating to the telephones, "It is the every resident with to a telephone for ploved ones and friet portable telephones charge for the use portable telephones Office. 4 must be Security Officer"	ill be a portable phone in the ing the daytime for emergency supervisor will carry the sight"  ty's written "Telephone" policy ent Rights (page 39) states, he right to have reasonable of a telephone where calls can eing overheard. Guidelines 1. offices or at nurse's stations ovisions of this requirement. include providing cordless telephone jacks in residents' at one telephone shall be ursing floor to accommodate chairs 4. A private line may esident's room All expenses hone are paid for by the hone" policy (page 40) policy of this facility to provide an opportunity to have access rivate conversations with each of the telephone. 3. The will be kept in the Security enough of the logged in and out by the		74			
	and E17, one staff r E19, were all intervi asked how they wou for a private phone a phone all stated	ed Nurses Aides), E15, E16, hurse, E18, and a Unit Clerk, ewed on 7/23/09. When all handle a resident's request call, if the resident did not own that they would take the es' station to use the					
	the second secon			•		1	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ	MULTIP	PLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		085012	B. WI			07/2	5/2009
NAME OF I	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	0774	0/2000
REGEN	CY HEALTHCARE & R	EHAB CENTER		1	1 N. BROOM STREET ILMINGTON, DE 19806	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 174	Continued From pa	ge 3	F	174			
	During an interview E20, stated that the	on 7/24/09, the receptionist, residents may use the lable in front of the front					
F 221 SS≐D	survey of residents the 2nd and 3rd floo outside the window multiple staff and/or the immediate vicinicalls. The facility fai access in a private a observations and minterviews and accortelephone policies. 483.13(a) PHYSICA	L RESTRAINTS  right to be free from any phosed for purposes of ence, and not required to	F2	221			
	This REQUIREMEN by: Based on record revinterview, it was deter to ensure that 3 sam and R90) had signed	T is not met as evidenced					
	(side rails). The facility ensure that R63, R20 restraints that were no symptom. Side rails was symptom.	ty additionally failed to ) and R90 were free from ot required to treat a medical were ordered for safety and R63 was no longer able to					
	cross refer F323						
014 0140 050	7/00 00) 0					<u></u>	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

TEATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTI	PLE CONS	TRUCTION	(X3) DATE SL COMPLE	
			A. BUII	LDIN	<sup>G</sup>		. OOMI EE	,,,
		085012	B. WIN	IG _	· · · · · · · · · · · · · · · · · · ·	<del></del>	07/25	5/2009
NAME OF F	PROVIDER OR SUPPLIER			STR	EÉT ADDR	ESS, CITY, STATE, ZIP CODE	·	
REGENO	Y HEALTHCARE &	REHAR CENTED				OM STREET		
	TIERETTOAKE &	KEHAD CENTER		W	/ILMING1	TON, DE 19806		·
(X4) ID		ATEMENT OF DEFICIENCIES	ID	j		PROVIDER'S PLAN OF CORREC		- (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI. TAG		(EA CROS	ACH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE OPRIATE	COMPLÉTION DATE
F 221	Continued From p	age 4	F 2	21				10/15/09
•	· ·	ed to the facility in 2004.						11-101
*	Diagnoses for R63	B included end stage dementia			F221		•	
*	with a mood disord	der, CVA (stroke) and		İ	1.	DON and Unit Nurse M	anager	
. *	blindness.	7				both spoke with the res		7
				į		party (daughter) for R63		
4"	An annual MDS (n	ninimum data set) assessment,		!		determined risks vs. be		1
		quarterly MDS, dated 5/29/09,				side rail use. Daughter	requested	1
		d severe cognitive impairment				continuation of side rail	s use for	
		y-term memory impairment.		Ì		use as an enabler for tu		
		pendent on staff for all care,			•	repositioning and to inc		
		resident moves to and from		.		resident's sense of safe		
		s side to side, and positions		}		security. Resident hold		5.
		required 2+ persons physical		.		side rail during incontin		
		e required a mechanical lift				changes. Unit Nurse Ma		•
	with 2 persons for	transfers.				obtained signed conser		er e
vi y	Deview of Deale a	فيترون والبدارية والماسية		ľ		rail use, and obtained p		1
4 <b>4</b> 1 4		are plan for side rails, dated dated 7/16/09, stated, " 2 1/2				order for side rail use.		
		nobility/an enabler to promote				updated care plan to re		
		actively participate in his/her				rail use as an enabler for and repositioning and to		
	own care".	douvery participate in marrier				resident's sense of safe		
						security at the request of		•
	Review of the 9/08	POS (physician order sheets)				resident's daughter/res		
		both *need consent signed*".				party. Unit Nurse Mana		
		cal record, however, lacked a				assessed both R20 and		
		vs. benefits for the use of a				side rail use risk vs. ber		
	restraint. From 10/	08 to the present, the POS'				rails were determined a	poropriate	
-		ails (full side rails currently in			` \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	for both residents for us	se in safety	
1.	place) for safety ar	nd mobility enablers."		į	:	and use as an enabler.		
				. !		Responsible parties we		
		on her back during multiple				contacted for both resid		À
		7/20/09 to 7/24/09. R63 was				signed consents obtain	and the second second	I .
		ng or repositioning herself at				Physician orders were		
		ent that R63 was aware that	٠.	į		both residents. RNAC	updated	2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -
	she had side rails i	n piace.			100	care plans.		
	Family intensions or	17/23/09 confirmed that R63						
	had not been able			ŀ	• -			
-	•	nabler for a "long time." It was		1				

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
•			A. BUILDING		
	tere,	085012	B. WING		07/25/2009
	PROVIDER OR SUPPLIER  CY HEALTHCARE & R	EHAB CENTER	80	ET ADDRESS, CITY, STATE, ZIP CO I N. BROOM STREET LMINGTON, DE 19806	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 221	also confirmed that family member was were advised of risk rails, but stated that them a few years at Facility assessment revealed that R63 d condition that requirindicated and serve independence.  Interview with E2 (D confirmed that physical lacked a diagnosis of confirmed lack of a restraint, including r 2. R20 was admitted diagnoses including	a consent was not signed; the uncertain as to whether they as vs. benefits for use of the the family had requested go.  s on 3/3/09 and 6/2/09 id not have a medical sed side rails nor were they d as enablers to promote  pirector of Nursing) on 7/22/09 ician orders for the side rails for medical symptoms. He also signed consent for the isks vs. benefits. It to the facility on 6/17/09 with stroke affecting her left side	F 221	<ol> <li>All residents who had bed mobility, fear of bed, or who request have the potential to by this deficient practions.</li> <li>Corrective actions in updating of Side Rate form to assess risk was ide rail use and to dindividual resident in rail use. Assessment includes checklist for benefit, physician or quarterly assessment which is done at quaresident care plans. corrective action will Restorative Nurse at physical/occupations will complete a week assessment audit to</li> </ol>	falling out of side rails, be affected ctice. Include il Assessment vs benefits of determine eed for side int form r need, risk der, and int follow up, arterly Further be that the indical therapist kly side rail
	retardation.  On 7/13/09, a Reha completed after R20 a Certified Occupati recommended, "sidbed". On 7/13/09, Frails for repositionin note stated, "Main to install side rails assessment cont. (of fall mats in place & Review of the clinical was no signed consideration.)	e rail to prevent roll out of R20's physician ordered, "side g" and at 11 PM a nurse's tenance to be notified of order SP (status post) fall continued) Bed in low position		are met. Unit Nurse Management and any needed documentation/interver RNAC will update care and at quarterly resider conferences.  4. Corrective Action will be monitored by DON or dononitored by DON or dononitor audits. Side Reseassessment audits will included in facility quarter.	ment criteria  anager will  ation and plans PRN nt care  e esignee by de rail ail be

CENTE	RTMENT OF HEALTH RS FOR MEDICARE	I AND HUMAN SERVICES  & MEDICAID SERVICES			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTA. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	0938-0391 JRVEY TED
		085012	B. WING_		07/2	5/2009
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	0112	J12003
REGEN	CY HEALTHCARE & R	EHAB CENTER		801 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 221	Continued From pa	ge 6	F 221			
	use of the side rails	On 7/24/09, findings were	; 22.1			
	January 31, 2009 w dementia, Parkinso depression. Admiss resident required to coded total assistan	s admitted to the facility on ith diagnosis including n's disease, dysphagia, ions assessment indicated all assistance. MDS was ce, two (2) person assistance bility 1 person assistance.				
	1/31/2009 determine appear to be indicated at the resident during the smalls were in use for in the resident's care revealed that 2 1/2 smalls were in use for in the resident R90. Care I "patient will fill out as Form". Review of the consent and risk vs. form for use of the refor R90 but were not condition. Additional discontinue the usagfacility's own assess were not needed.	e of the side rails when the ments showed the side rails				
	the lack of a Side Ra restraint use by this i was obtained for the on 7/23/2009.	rector of Nursing, confirmed il Consent form for the esident. A physician's order use of bilateral 1/2 side rails				
F 241	483.15(a) DIGNITY		F 241		-	
	The facility must pror	note care for residents in a			-	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONS DING	TRUCTION	(X3) DATE S COMPLE	
· · · · · · · · · · · · · · · · · · ·		085012	B. WINC	3		07/2	5/2009
REGENO	PROVIDER OR SUPPLIER  OY HEALTHCARE &	REHAB CENTER		801 N. BRC	RESS, CITY, STATE, ZIP CODE DOM STREET TON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	PROVIDER'S PLAN OF CORRE ACH CORRECTIVE ACTION SI SS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	enhances each refull recognition of  This REQUIREMI by: Based on observa determined that the many residents we manner. Resident during meals with beverage glasses hand, was unable received no assist	environment that maintains or esident's dignity and respect in his or her individuality.  ENT is not met as evidenced ations and interviews it was be facility failed to ensure that ere treated in a dignified to the ensure that every entire provided with a carton sout being provided with a R72, who only had use of one to open her milk carton and trance from staff. R29 was not treat within a there are idented to be a carton and trance from staff.		2.	be affected by this de practice. Corrective Actions inc monitoring by Food S Director to ensure all milk cartons will have glasses. Wait style di	th R72 and vere given al assistance ent meals. to home on e potential to ficient clude tervice trays with beverage ining will be	
	table ate their mer of incontinence du answered in a time.  1. Throughout the 7/24/09, observation being served milk times. Since no gwere observed dricartons. During d 5:30 PM, R72, who asked a surveyor as no staff was avassistance.  2. During a dining PM, R29 was observed to the residents who waited 5 to 10 min asked staff if she asaid was sitting or	tray while other residents at her als. R34 experienced episodes at to call lights not being ely manner. Findings include:  survey, from 7/20/09 through ons were made of residents from cartons during meal lasses were provided, residents nking directly from the milk ining observations on 7/23/09 at o only had use of one hand, to open her milk carton for her ailable to provide her with  observation on 7/23/09 at 5:30 erved sitting at a table with two no were eating their meals. She nutes for her dinner, then finally could have her tray which she is a table behind the cart. Staff serve the resident until she			initiated in the facility October 15, 2009 and the problem of missin residents who change decision in choice of ollocations. Dietary will weekly test tray to endishware and utensils resident trays. All fact be in-serviced on new delivery system of wa dining. Staff Educator facility wide in-servicin regarding psychotropi medications having si potential for urinary un incontinence and that attention to toileting in needed in cases when medications are newly residents.	I will resolve g trays on e their dining I have a sure s are on sility staff will w meal ait style will conduct ng for staff ic ide effects of rgency and increased eeds will be re these	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IULTIPLE CONSTRUCTION LDING	(X3) DATE SURVEY COMPLETED	
			B. WIN		-	
		085012			07/25/2009	
	PROVIDER OR SUPPLIER  OY HEALTHCARE & F	REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP 801 N. BROOM STREET WILMINGTON, DE 19806	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE COMPLE HE APPROPRIATE DATE	
F 241	Findings were acking Regional Food Service Directors of Service Director	nowledged by E12, the vice Manager and E13, the	F 2	4. Corrective action we monitored by the F Director through a Operational Score a QI report) which we trays, tray audits, restriction surveys service temperature style dining service monitored on an or monthly Resident C Meetings. Staff Ed maintain in-service psychotropic medic urinary side effects	cood Service monthly Card (roll up of will include test esident s, and pre- e results. Wait issues will be going basis at council ucator will logs on ation and	
	stated that R34 is any pads. Additional stated that R34 is a remember one incided to go to the batollet in time.  On 7/25/09, during she used a roller with the rewere a few in the day related to he	an interview E10, a CNA, continent and does not wear ally, on 7/23/09, E11, a CNA, continent but the CNA did dent when R34 knew that she throom but could not get to the an interview, R34 stated that alker and required assistance ng. R34 stated that in May stances of incontinence during taving to wait a long time for her call light. This resulted in to hold her urine.				
-		provide care in a manner that dignity. On 7/25/09, findings				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  (X2) ID PREFIX TAG  (X3) ID PREFIX TAG  (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (X5) ID PREFIX TAG  (X6) ID PREFIX TAG  (X7) MAIN TAG  (X7) MAIN TAG  (X7) MAIN TAG  (X7) MAIN TAG  (X8) ID PREFIX TAG  (X7) MAIN TAG  (X8) ID PREFIX TAG  (X8) MAIN TAG  (X8) ID PREFIX TAG  (X8) ID PREFIX TAG  (X8) ID PREFIX TAG  (X8) ID PREFIX TAG  (X9) MAIN TAG  (EACH CORRECTIVE ACTION HOURS TRUCTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION HOURS TREFIX  (EACH CORRECTIVE ACTION HOURS TREFIX  (EACH CORRECTIVE ACTION HOURS TREFIX  (EACH CORRECTIVE ACTION HOURS TREFIX  (III) MAIN TAG  (EACH CORRECTIVE ACTIO	PARTMENT OF HEALTH AND HUMAN SERVI INTERS FOR MEDICARE & MEDICAID SERVIC	PRINTED: 10/09/2009 FORM APPROVED OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  (X4) ID PREFIX TAG  F 241  Continued From page 9  were reviewed with the administrative staff at the informational meeting. F 242  SS=E  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by; Based upon observation, interviews and document review the facility failed to reasonably accommodate preferences of residents related to food choices for 4 residents (R62, R41, R13 and R6). Additionally, Resident Council Meetings in the past 3 months noted that Items were missing from trays. R13 and R41 had items listed on their meal tickets that were missing when test trays were assessed by surveyors. R62, a resident with	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/	(X3) DATE SURVEY COMPLETED
REGENCY HEALTHCARE & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 241  Continued From page 9  were reviewed with the administrative staff at the informational meeting.  F 242 483.15(b) SELF-DETERMINATION AND PARTICIPATION  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based upon observation, interviews and document review the facility failed to reasonably accommodate preferences of residents related to food choices for 4 residents (R62, R41, R13 and R6). Additionally, Resident Council Meetings in the past 3 months noted that items were missing from trays. R13 and R41 had items listed on their meal tickets that were missing when test trays were assessed by surveyors. R62, a resident with	085012	- 07/2 <u>5/200</u> 9
FREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 241  Continued From page 9  Were reviewed with the administrative staff at the informational meeting.  F 242  SS=E  PARTICIPATION  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by:  Based upon observation, interviews and document review the facility failed to reasonably accommodate preferences of residents related to food choices for 4 residents (R62, R41, R13 and R6). Additionally, Resident Council Meetings in the past 3 months noted that items were missing from trays. R13 and R41 had items listed on their meal tickets that were missing when test trays were assessed by surveyors. R62, a resident with		ZIP CODE
were reviewed with the administrative staff at the informational meeting.  F 242 SS=E  RATTICIPATION  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based upon observation, interviews and document review the facility failed to reasonably accommodate preferences of residents related to food choices for 4 residents (R62, R41, R13 and R6). Additionally, Resident Council Meetings in the past 3 months noted that items were missing from trays. R13 and R41 had items listed on their meal tickets that were missing when test trays were assessed by surveyors. R62, a resident with	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU	ACTION SHOULD BE COMPLETION DATE DATE
diabetes, incorrectly had sugar packets on his tray. R6 was receiving a mechanical soft diet when she had been requesting and ordered to receive a regular diet. Findings include:	were reviewed with the administrative state informational meeting. 483.15(b) SELF-DETERMINATION AND PARTICIPATION  The resident has the right to choose active schedules, and health care consistent with her interests, assessments, and plans of conteract with members of the community be inside and outside the facility; and make considerated about aspects of his or her life in the facility are significant to the resident.  This REQUIREMENT is not met as evided by: Based upon observation, interviews and document review the facility failed to reast accommodate preferences of residents refood choices for 4 residents (R62, R41, R6). Additionally, Resident Council Meeting the past 3 months noted that items were infrom trays. R13 and R41 had items listed meal tickets that were missing when test the were assessed by surveyors. R62, a residuabetes, incorrectly had sugar packets of tray. R6 was receiving a mechanical soft of when she had been requesting and ordered.	1, R13, and R6 to sues further and dent specific Food Service nservice dietary staff have the potential to y this deficient y audits to be eekly with a 00% compliance staff. Tray accuracy tracked weekly and erational Scorecard. ction will be the Food Servcie ugh monthly Scorecard which will rays, tray audits,
Review of Resident Council meeting minutes from 4/09, 5/09 and 6/09 revealed that residents expressed concern that items were often missing from meal trays. Additionally, residents complained that specific food requests were not always honored. On 7/20/09, in an interview with R15, the Resident Council President, she confirmed that there were multiple complaints about food trays at the meetings.	from 4/09, 5/09 and 6/09 revealed that resexpressed concern that items were often from meal trays. Additionally, residents complained that specific food requests we always honored. On 7/20/09, in an intervie R15, the Resident Council President, she confirmed that there were multiple complained.	

しにてよれ	TWENT OF HEALTH	AND HUMAN SERVICES				FRINTED	: 10/09/2009
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S	URVEY .
			B. WIN	عدا			
NAMEOF		085012	D. VVII	·		07/2	5/2009
IVAIVIE OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
REGENO	Y HEALTHCARE & R	EHAB CENTER			01 N. BROOM STREET VILMINGTON, DE 19806		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	JD		PROVIDER'S PLAN OF CORREC	TIÓN	(X5)
PREFIX TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION DATE
					DEFICIENCY)		ļ
F 242	Continued From page	ge 10	F2	42			
	1 P62 was admitted	A to the faction of Fideros in		į			
	diagnoses including	d to the facility on 5/15/09 with insulin dependent diabetes		.			<b>)</b>
	and stroke The 7/0	9 physician order sheet (POS)					
	listed R62's diet as	carbohydrate controlled diet	,				
	(CCD), On 7/23/09.	R62 incorrectly received 6		.			
	sugar packets on his	s dinner tray instead of the 6					
	sugar substitute pac	kets despite the meal ticket	* .				
	which listed R62's d	iet as CCD with 6 sugar					
	substitute packets. F	R62 also stated that his salt					
	packet was wet and	unable to be used.					
	The feature for in-		2.1				
	with P62's plan of as	provide choices consistent					
	him sugar on his din	re due to incorrectly giving ner tray and an unusable salt	•	-			
. 1	nacket: On 7/23/00	findings were acknowledged	* * * * * * * * * * * * * * * * * * * *				
	by E14 (unit clerk) w	ho called the kitchen to					
4	request the sugar su	bstitute and salt packets.	5		•		
	2. On 7/23/09, R41 a	greed to let surveyors use		İ			
	his dinner tray as a t	est tray. When the tray was					
	assessed the following	ng items were missing: 8 oz.					· ·
'	water, 1 pepper pack	ket, and 1 margarine.					- 1
.	The facility failed to r	provide items R41 had					ļ
	chosen to be on his t	rav					
	3. R13 was admitted	to the facility with diagnoses					
.   t	hat included emphys	sema, weight loss and severe		• 1			
9	gastritis.	3					
1  .	During an interview w	vith R13 on 7/21/09, he		1			
S	stated that he had as	ked for oatmeal and boiled			· · · · · · · · · · · · · · · · · · ·	-	
.   6	eggs for breakfast, bi	ut he did not always receive					
.   I	nem. He stated that	since he only had bottom		-		İ	
ا	eem he could not ch isked to have catmo	ew everything and that he all at every meal but he				İ	
l n	arely received if Ad	ditionally, he stated that he					1
l a	isked for three sugar	s on each meal tray but he					ł
u	isually did not receive	e them.		-			• ]
				!	· · · · · · · · · · · · · · · · · · ·		

CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			FC	DRM APPROVED NO. 0938-0391
STATEME AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		085012	B, Wil	IG		07/25/2009
	PROVIDER OR SUPPLIER  CY HEALTHCARE & R	EHAB CENTER		STREET ADDRESS, CITY, STATE 801 N. BROOM STREET WILMINGTON, DE 19806	, ZIP CODE	3772312003
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 242	Continued From page	ge 11	F 2	42		
	7/21/09, 7/22/09 and boiled eggs should however, no eggs w	akfast meal tickets on I 7/23/09 indicated that two nave been on the trays, ere observed. On 7/23/09, s pulled as a test fray. The				
	meal ticket indicated included cottage che and 3 sugars. Obse that these items wer lunch ticket indicated	that the tray should have bese, margarine, two peppers, rvation of the tray revealed e missing. On 7/24/09, R13's I that oatmeal should have no oatmeal was observed.				
	The facility failed to h	nonor R13's choices.				
, ·	4. R6 was an alert ar	oriented resident.				
	PM, R6 was observe lunch. Her meal tick a mechanical soft die that meal. R6 stated	ervation on 7/20/09 at 12:40 d in the dining room eating et indicated that she received at which she did receive for that she had been asking food but they were not				
	7/20/09, she stated the therapy did not feel the food. She later stated speech therapist who	with the dietitian, E8 on the state of the s				
	An interview with R6, revealed that she receded that she receded not like.	on 7/21/09 at 9:00 AM, eived ground food which she				
	During a dining obser PM, R6 stated that sh	vation on 7/24/09 at 12:30 e was still receiving				
M CMS-256	7(02-99) Previous Versions Ob	solete Event ID: JRVC11		i acility ID: DE0065	If continuation she	ot Page 13 of 55

CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION	(X3) DATE SI	
		085012	B. WII			07/0	r/2000
NAME OF	PROVIDER OR SUPPLIER			CTD	DEET ADDRESS OFFI OFFI		5/2009
REGEN	CY HEALTHCARE & R	EHAB CENTER	-	81	REET ADDRESS, CITY, STATE, ZIP COU 01 N. BROOM STREET VILMINGTON, DE 19806	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242	Continued From pa	ne 12	-	340			
Ť	chopped food. Sho was observed servi however, there was	rtly after the interview, staff ng R6 a regular hamburger, no meal ticket that	F2	242			
	the resident's diet	nner to reflect the change in		) 			• 5
	R41, R13 by omittin and for R6 by not pr consistency that she acknowledged by E Manager and E13, t 7/24/09.	honor the dietary requests of g items from their meal trays oviding her with the food e requested, Findings were 12, the Regional Food Service he Food Service Director on			F247  1. No specific intervent with R86 but as a res		10/1/09
F 247 SS=B	A resident has the ri	E BEFORE ROOM CHANGE ght to receive notice before or roommate in the facility is	F 2	47	situation, Social Service developed a Roomm notification form.  2. All residents have the be affected by this depractice.	vice Director late Change e potential to	
	by: Based on resident a determined that the	T is not met as evidenced nd staff interview it was facility falled to inform at least dent (R86) of a roommate clude:			3. All resident room changes/roommate of the authorized by Social Service (Admission Director). Social Servill meet with roommaresident leaving a roommaresident.  3. All resident room and the service of the service	cial Services ions vice Director nate of om, or	
F 248 SS=D	E9, the facility social receive advanced no 483.15(f)(1) ACTIVIT The facility must provof activities designed the comprehensive a	erviews and staff interview, worker, residents do not tice of a roommate change. IES vide for an ongoing program to meet, in accordance with ssessment, the interests and and psychosocial welf-being	F 24	18	roommate to receive resident into the roor resident sign notifica roommate change.  4. Corrective action will monitored by Social Director by follow up resident room change Roommate Change been initiated and co	n, and have tion form of be Service on each e to ensure form has	
	Of each resident.						

STATEBIRT OF EPOTOCHAPES  AND PLAN OF CORRECTION  NAME OF PROVIDERS (XI) PROVIDER/SUPPLIER/REVIEW (COMPLETED  OR 5012  NAME OF PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STATE ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STATE ADDRESS, CITY, STATE_UP CODE  STREET ADDRESS, CITY, STATE_UP CODE  STATE ADDRESS, CITY, STATE_UP CODE  STATE ADDRESS, CITY, STATE_UP CODE  STATE ADDRESS, CITY, STATE_UP CODE  STATE ADDRESS, CITY, STATE_UP CODE  STATE ADDRESS	DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PKINTED: 10/09/2009
STATEMENT OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  (AC) ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST are plan and assessment to provide an ongoing activity program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial wiell-being for 2 (R8 and R20) sampled residents. The facility failed to provide additional in room activities appropriate for R20 after she sustained a humeral fracture in the facility. Findings include.  Cross refer to F250  1. R8 was admitted to the facility in 3/05. Her diagnoses included: language barrier and Alzheimer's dementia with depression.  The facility care planned for " impaired communication related to language barrier resident speaks: Chinese." Approaches included, " 4. Use gestures when necessary 7. Family to assist with translation 9. Involve resident in activities which do not depend on residents ability to communicatie. music, parties, movies, etc"  On 11/28/09, the approach "Chinese enewspapers/liferature, etc. have stopped coming to the facility. Family made aware. States they will amend." The care plan was developed on 7/23/08 and was last reviewed on 7/23/09, listed goals  A "potential for social isolation d/t (due to) language barrier" care plan, developed on 6/19/08 and last reviewed on 7/23/09, listed goals  A "potential for social isolation d/t (due to) language barrier" care plan, developed on 6/19/08 and last reviewed on 7/23/09, listed goals	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED
NAME OF PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES  OVA 1D PREFIX TAG  RECURS DEFICIENCY MUST BE PRECEDED BY FULL FEDULATION ON THE PRECEDED BY FULL FEDULATION OR 1S.0 IDENTIFY IN MERCANATION)  F 248  Continued From page 15  The REQUIREMENT is not met as evidenced by. Based on record review, observation and interview it was determined that the facility failed to provide anongoing activity program designed to meet, in accordance with the comprehensive assessment, the interests and this physical, mental, and psychosocial well-being for 2 (R8 and R20) sampled residents. The facility failed to follow the care plan and assessments developed for R8 regarding activities of interest. The facility failed to provide additional in room activities appropriate for R20 after she sustained a humeral fracture in the facility. Findings include:  Cross refer to F250  1. R6 was admitted to the facility. Findings include:  The facility care planned for " impaired communication related to: language barrier, resident speaks: Chinese." Approaches included, " 4. Use gestures when necessary 7. Family to assist with translation. 9. Invited to the facility to communication: while the communication related to: language barrier, resident speaks: Chinese." Approaches included, " 4. Use gestures when necessary 7. Family to assist with translation. 9. Invited to the facility for communication related to: language barrier, resident in activities which do not depend on residents's ability to communication: unside, parties, movies, etc On 11/28/08, the approach "Chinese enewspapersiliterature, etc. have stopped coming to the facility, Finding made aware. States they will amend." The care plan was developed on 7/23/08 and was text reviewed on 7/23/09, listed goals  A "potential for social isolation d/t (due to) language barrier" care plan, developed on 6/19/08 and last reviewed on 7/23/09, listed goals	STATEMEN	T OF DEFICIENCIES				
NAME OF PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  OX40 ID PREETX (EACH DEFICIENCY MUST SEP PRECEDED BY PULL TAG PRECEDED	AND PLAN	OF CORRECTION	(A1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	
NAME OF PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  SUMMARY STATEMENT OF DEPICIENCIES TAG  SUMMARY STATEMENT OF DEPICIENCIES TAG  CONTINUED FROM INCOME TO BE DEPICE OF TOLL REGULATIONY OF USE DEPICE OF TOLL TAG  F 248  Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to provide an ongoing activity program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being for 2 (R8 and R20) sampled residents. The facility failed to provide additional in room activities appropriate for R20 after she sustained a humeral fracture in the facility. Findings include:  Cross refer to F250 1. R8 was admitted to the facility in 3/05. Her diagnoses include: language barrier and Alzheimer's dementia with depression.  The facility care planned for " impaired communication related to Language barrier, resident speaks: Chinese." Approaches included, " 4. Use gestures when necessary. 7. Family to assist with translation. 9. Involve resident in activities which do not depend on resident's ability to communicater, music, parties, movies, etc.". On 11/28/09, the approach "Chinese and was last reviewed on 2/23/09.  A "potential for social isolation of /f (due to) language barrier" care plan, developed on 6/19/08 and last reviewed on 2/23/09. Isdeed to succeed the communication of facility in communication of facility in communication of facility of an alsat reviewed on 2/23/09. Isdeed to succeed the communication of facility in a social isolation of facility of an last reviewed on 2/23/09. Isdeed to wash independently in room. Use Netfitx as primary resident to wash to be provided in Chinese. Approaches included.  - Language barrier" care plan, developed on 6/19/08 and last reviewed on 2/23/09, listed quals			TO THE TOWNS CO.	A. BUILDI	NG	COMPLETED
NAME OF PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  SUMMARY STATEMENT OF DEPICIENCIES TAG  SUMMARY STATEMENT OF DEPICIENCIES TAG  CONTINUED FROM INCOME TO BE DEPICE OF TOLL REGULATIONY OF USE DEPICE OF TOLL TAG  F 248  Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility failed to provide an ongoing activity program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being for 2 (R8 and R20) sampled residents. The facility failed to provide additional in room activities appropriate for R20 after she sustained a humeral fracture in the facility. Findings include:  Cross refer to F250 1. R8 was admitted to the facility in 3/05. Her diagnoses include: language barrier and Alzheimer's dementia with depression.  The facility care planned for " impaired communication related to Language barrier, resident speaks: Chinese." Approaches included, " 4. Use gestures when necessary. 7. Family to assist with translation. 9. Involve resident in activities which do not depend on resident's ability to communicater, music, parties, movies, etc.". On 11/28/09, the approach "Chinese and was last reviewed on 2/23/09.  A "potential for social isolation of /f (due to) language barrier" care plan, developed on 6/19/08 and last reviewed on 2/23/09. Isdeed to succeed the communication of facility in communication of facility in communication of facility of an alsat reviewed on 2/23/09. Isdeed to succeed the communication of facility in a social isolation of facility of an last reviewed on 2/23/09. Isdeed to wash independently in room. Use Netfitx as primary resident to wash to be provided in Chinese. Approaches included.  - Language barrier" care plan, developed on 6/19/08 and last reviewed on 2/23/09, listed quals				D VA/INIC		
REGENCY HEALTHCARE & REHAB CENTER    Dot   D	NAME OF S		085012	B. WING_		07/25/2009
SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX   PROVIDER'S PLAN OF CORRECTION   PREFIX   PROVIDER'S PLAN OF COMPACING NO.	NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
PREFIX TAG  SUMMARY STATEMENT OF DETICLENCIES (EACH DEFICIENCY WILD IT DETICENCY   Based on record review, observation and interview it was defermined that the facility failed to meet, interests and the physical, mental, and psychosocial well-being for 2 (R8 and R20) sampled resident R8 includes with resident R8 includes with resident R8 includes with resident R8 includes with resident R8 includes with resident R8 includes with resident R8 includes with resident R8 includes with resident R8 includes with resident R8 includes the year with resident R8 includes with resident R8 includes the year with resident R8 includes with resident R8 includes with resident R8 includes with resident R8 includes with resident R8 includes the year with resident R8 includes with resident R8 includes the year with resident R8 includes with resident R8 includes the year with resident R8 includes with resident R8 includes the year with resident R8 includes with resident R8 includes the year with resident R8 includes the year with resident R8 in	REGENO	CY HEALTHCARE & R	EHAB CENTER			
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 248  Continued From page 13  This REQUIREMENT is not met as evidenced by:  Based on record review, observation and interview it was determined that the facility failed to provide an ongoing activity program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being for 2 (R8 and R2O) sampled residents. The facility failed to follow the care plan and assessments developed for R8 regarding activities of interest. The facility failed to provide additional in room activities appropriate for R2O after she sustained a humeral fracture in the facility. Findings include:  The facility care planned for ",, impaired communication related to: language barrier, resident speaks; Chinese," Approaches included, ", 4. Use gestures when necessary 7. Family to assist with translation 9. Involve resident in activities which do not depend on resident's ability to communicate: music, parties, movies, etc" On 11/28/09, the approach "Chinese newspapers/liferature, etc. have stopped coming to the facility. Family made aware. States they will amend." The care plan made developed on 7/23/09 and was last reviewed on 2/23/09.  A "potential for social isolation d/t (due to) language barrier" care plan, developed on 6/19/08 and last revised on 5/28/09, listed goals	(X4) ID	SUMMARY STA	TEMENT OF DECICIONOUS		The state of the s	
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" 4 Use gestures when necessary 7. Family to assist with translation 9. Involve resident in activities which do not depend on resident's ability to communicate: music, parties, movies, etc".  On 11/28/09, the approach "Chinese newspapers/literature, etc. have stopped coming to the facility. Family made aware. States they will amend." The care plan was developed on 7/23/08 and was last reviewed on 2/23/09.  A "potential for social isolation d/t (due to) language barrier" care plan, developed on 6/19/08 and last revised on 5/29/09, listed goals  organizations/churches with members from native country who speak native language.  - Family to provide resident with publications of native language for daily reading or as desired by resident.  - Provide videos, documentaries/movies of native language weekly or as desired by resident to watch independently in room. Use Netflix as primary resource. A DVD player was		resident speaks: Chi	nese." Approaches included.			
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language weekly or as desired by A "potential for social isolation d/t (due to) language barrier" care plan, developed on 6/19/08 and last revised on 5/29/09, listed goals  language weekly or as desired by resident to watch independently in room. Use Netflix as primary resource. A DVD player was		and was last reviewe	d on 2/23/09.			es of native
A "potential for social isolation d/t (due to) language barrier" care plan, developed on 6/19/08 and last revised on 5/29/09, listed goals  resident to watch independently in room. Use Netflix as primary resource. A DVD player was			· ]			
language barrier" care plan, developed on 6/19/08 and last revised on 5/29/09, listed goals in room. Use Netflix as primary resource. A DVD player was	_	A "potential for socia	l isolation d/t (due to)			
6/19/08 and last revised on 5/29/09, listed goals resource. A DVD player was	1	language barrier" car	e plan, developed on			
including." continue to get needs satisfied nurchased for resident	16	6/19/08 and last revis	sed on 5/29/09 listed goals			
	1	includina: " continu	e to get needs satisfied			
through family visits, and 1:1 room visits,  Corrective actions for R20		through family visits	and 1.1 room visits			
invitation to group activities of choice daily."		nvitation to group ac	tivities of choice daily "	· · · · · · · · · · · · · · · · · · ·	2020070 000010 101	

CENTE	RS FOR MEDICARE & MEDICAID SERVICES			FORM	, TU/U9/ZUU9 I APPROVED
STATEMEN	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	(X3) DATE S COMPLI	. 0938-0391 URVEY ETED
	085012		NG	07/0	15/2000
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS CITY OF AT	0712	5/2009
REGEN	CY HEALTHCARE & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	1
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREF TAG	IX (EACH CORRECTIVE ACTION SHO	ULDBE	(X5) COMPLETION DATE
	Approaches included, " Will continue to invite and escort to programs of interest will invite to facilities bus trip program at least once per month "Shopping" Provide daily room visits".  The facility also care planned for "Resident is being treated for indicators of depression i.e. hopelessness, sadness, withdrawal, etc." on 7/23/08 (updated on 2/23/09). Approaches included, " 4. Encourage to attend and participate in activities of known interest. 5. Meet with on a 1:1 basis and encourage expression of feelings 10. Encourage family/pet visits."  R8's annual MDS (minimum data set) assessment, dated 2/21/09, listed general activity preferences as arts/crafts, exercise/sports, music, watching TV, and talking or conversing.  Activity sheets from 2/09 to 7/09 were reviewed. The majority of activities R8 attended and was "active" in included, meet and greet, word games/trivia/reminisce, and movie/video/TV. R8 actively participated in party/social entertainment 5 times and she declined this activity 13 times. She actively participated in food socials/breakfast club/monthly birthday parties 11 times, while declining the activity 10 times. She attended arts and crafts/ceramics once in over 5 1/2 months	F 2	include: - Activity Director is now attadaily clinical meeting to be informed of any significant change in resident status the potentially could affect leisure participation Care plans will be updated revised on quarterly basis or significant change by Activity Director Activity Director will hold dameetings with activity staff to discuss any change in reside status regarding activity participation Communication book was eliminated. Speech therapis designed a Chinese communication board with pictures for resident. Soci Worker posted in resident and staff were in-serviced of Chinese communication 2. All residents have the pote be affected by the deficient practice.  3. For resident R8: - All activity staff will be in-	at re and with / aily ents'	
-	and declined once, and she actively participated in exercise/active games 5 times. Exercise/active games was declined once and another time R8 napped through the activity. The only outing or bus trip listed was a leave of absence with R8's family on 4/6/09. There was no documentation of 1:1 visits or pet visits.		serviced on proper documentation of refusals a active participation vs. pass participation.	and iive	
[	During an interview with E21 (activity aide) on 7/24/09, E21 stated that although R8 was social,				
RM CMS-2567	7(02-99) Previous Versions Obsolete Event ID: JRVC11		Facility ID: DE0065	1	

		AND HUMAN SERVICES  & MEDICAID SERVICES			FORM	: 10/09/2009 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE S	URVEY
		085012	B. WING_	<u> </u>	07/2	5/2009
NAME OF P	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CODE		312003
REGENC	Y HEALTHCARE & R	EHAB CENTER	8	801 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE PROPRIATE	(X5) COMPLETION DATE
F 248	many activities. E21 TV, music, having h E21 stated that R8 magazines and she	uage barrier, R8 refused stated that R8 liked watching er nails done, and shopping. used to get Chinese was "looking into that."	F 248	<ul> <li>Activity Director will mon participation logs weekly f missed documentation or improper documentation b for immediate correction.</li> <li>Significant decline in actiparticipation will be define</li> </ul>	or by staff vity	
	with E21. E21 confir provided to R8 nor v bus trips at least on the last time she red was an ice cream se	2/09 to 7/09 were reviewed med that 1:1 visits were not was R8 offered out of facility ce per month. E21 stated that called R8 going on a bus trip ocial last year. E21 confirmed or activities was not followed.		increase in refusal of active interest by at least 30% in week period.  - Quarterly documentation medical record will clearly leisure participation in groundividual activity and external increase.	ities of a 2 in indicate ups and nt of	
. :	7/24/09. E26 and E2 couch in the lounge on the floor in which They stated that R8 lounge and they had word games/trivia/re sheets indicated that these activities near watched Chinese m	(CNA) were interviewed on 27 stated that R8 sits on the in front of the nurses station she resides watching people does not watch TV in the I not observed R8 engaged in eminisce, although activity t R8 actively engaged in ly every day. They stated R8 ovies in her room that her vever, most of the time she		involvement i.e. refused, a passive, etc. Care plans we updated or revised to indict goal achievement or declined Care plans will be updated clearly indicate specific less interest.  For resident R20:  In addition to quarterly up Activity Director will review plans at interdisciplinary care.	vill be ate ate to sure odates, care	
	would fall asleep.  A Care Conference stated, " does not residents. + (positive speaks Chinese and cooperative Activitinvitation by staff. Not Multiple observation revealed R8 sleeping	Record for R8, dated 5/29/09, interact c (with) staff or c) Language barrier- res. 10 (no) English but is ies of choice. May refuse		meetings. Residents with significant of in status affecting leisure participation will be put on or provided with adaptation enable continued participal leisure activities of choice. Corrective actions will be monitored for resident R8: - Participation logs will be monitored weekly to ensure proper documentation by significant continued.	a 1:1 is to ion in	
:	sitting quietly on the of the nurses station	couch in the lounge in front looking around. R8 was not ttching TV or engaging in any		independent and group participation Activity Director will imple quarterly QI study to track	ment	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 10/09/2009 FORM APPROVED
		& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		085012	B. WING		07/25/2009
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	111201200
REGEN	CY HEALTHCARE & R	EHAB CENTER		801 N. BROOM STREET WILMINGTON, DE 19806	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 248	Continued From pa	ge 16	F 248		
	activities during the activity staff) were not seen enco activities she attend visitors were seen of On 7/23/09, E28 (actalking to multiple relounge while baking residents were gath offered drinks while asked if they preferr cookies. R8 sat on the from the other residents a drink and she was cookies. The only coduring the activity when the cookies stated, "be careful, it cookies. An activity is cookies. An activity is seen activity in the cookies. An activity is seen activity in the cookies. An activity is seen activity in the cookies. An activity is seen activity in the cookies. An activity is seen activity in the cookies. An activity is seen activity in the cookies.	survey. Staff (including of observed trying to ning activities to R8 and they uraging R8's participation in ed. No family members or uring the survey.  Itivity aide) was observed sidents on the 2nd floor cookies. Most of the ered near E28. They were the cookies baked and then ed sugar or chocolate chip he couch in the lounge away ents, was not offered or given not given a choice of onversation from E28 to R8 as when R8 held her hands is were given to her, E28 it's hot." R8 quietly ate her note, dated 7/2/309, stated,	F 248	participation in activities of interest for those residents or planned for language barrier.  Activity Director will continum monitor participation logs to ensure independent leisure activities such as movies, volunteer visits and publications/materials are be provided weekly.  Corrective actions will be monitored for R20:  Activity Director will impler quarterly QI study to track a resident with significant cha appropriately care planned any interventions have been in place and are effective.  With any readmit to facility hospital stay, Activity Director review care plan and imples	nent ny nge is and n put
	" decline (sic) to pa	articipate with baking, after		any necessary changes.	
	musimid naking she	enjoyed tasting the cookies."			
	got a Beijing website shared with R8. R8 I	trainer with the survey team on her laptop which she became excited and clapped sic and she actively read the se.			
			*		
	regard to activities.  2. R20 was admitted diagnoses including	to the facility on 6/17/09 with stroke affecting her left side			
ŀ	retardation. On 7/14/	ol, atrial fibulation and mental 09, R20 fell out of bed and nerus (Upper arm/shoulder).			
		nt for Activities, dated			

		I AND HUMAN SERVICES & MEDICAID SERVICES		٠.			FORM	10/09/2009 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TPLE CONSTRUCTION	(X3) DATE S COMPLE		
		085012	B. WI	NG_			07/2	5/2009
NAME OF	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CIT	Y, STATE, ZIP CODE		
REGEN	CY HEALTHCARE & R	EHAB CENTER		1	301 N. BROOM STR WILMINGTON, DE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	ــنــل	PROVIDE	R'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC			RECTIVE ACTION SH RENCED TO THE API DEFICIENCY)		(X5) COMPLETION DATE
F 248	Continued From pa	ige 17	F	248	-		· · · · · · · · · · · · · · · · · · ·	
		hat R20 's vision was						
		ses, she had good hearing,		٠.				
		inication and was able to					• *	
	make her needs kn	own. The assessment listed			·.	•		
		ests as games including Bingo					*.	
		exercise, music, reading,			1:		-	
,	watching TV and ta	lking.				•		
						1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		
		lan, dated 6/26/09, had a plan						
* ,		group activities on and off unit						
		ndependent activity such as oviding reading materials for						
	R20 to use.	oviding reading materials for				, *	$\mathcal{A}_{i}^{(t)}$ . The $\mathcal{A}_{i}$	
	1120 to use.						•	
	Multiple observation	ns were made on 7/20, 7/21					· ·	
		ing awake in her bed, without						
		read, or listening to music.						
:		ervations from 7/20/09 through		·				- :
		vely participating in any crafts,	٠.					
	games, or group ac	tivities.	• •					
				· ·.			. ,	
		corded that R20 actively	•					
	Chat/Snack & Chat	et and Greet/Morning						
the second		nisce" and Movie/Video/TV"				•		
		7/23. On 7/24/09, an						
		Activity Aide, revealed "Meet				•	•	
		a brief visit into the residents'					• :	
-	rooms. E21 also sta	ated that at times R20, "will be						
		on while activities are						
		atch an activity." E21 stated	-					-
		een revisions to the Activities						
ĺ	program for R20 aff	er her fracture.						
	THE ELECTION OF THE			٠		*	٠	
		provide for an ongoing						.
		s designed to meet R20's ner change in status. On				· ·		!
		ere acknowledged by E21 and			; 4 2			
		ved on 7/25/09 with the						i .

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					APPROVED
		& MEDICAID SERVICES					0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CONS	TRUCTION	(X3) DATE SI COMPLE	URVEY
* .		085012	B. WIN			07/2	5/2009
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP CODE	1	0,200
REGENO	Y HEALTHCARE & R	EHAB CENTER		801 N. BRC	OOM STREET TON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TÉMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E/	PROVIDER'S PLAN OF CORRE ACH CORRECTIVE ACTION SH SS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 248	Continued From pa	ae 18	F 2	18	-		
F 250 SS=D	administrative staff 483.15(g)(1) SOCI/	at the informational meeting. AL SERVICES		50			101.100
• .		ovide medically-related social maintain the highest				* * *	10/1/09
	well-being of each reach reach the second of	NT is not met as evidenced cord review, observation and ermined that the facility failed related social services to be highest practicable eing for one sampled resident		F250 1	Speech Pathologist a communication asse done on R8. Speech will trial a communication with resident and the the staff once an approximation board Social Service Direct "Sensory Assessmen All residents have the	and a ssment was therapist ation board in in-service oropriate d is finalized or created a tr tool. e potential to	1.
	unmet needs relate interaction and soci include: cross-refer F248, ex	e speaking resident, had d to difficulty with personal alization skills. Findings  kample #1 the facility in 3/05. Diagnoses		3.	be affected by the de process. Social Service Direct conduct ongoing assocommunication barrieneeds of residents at admission/readmission	or will essments of ers and	F
	for this resident incl Alzheimer's dement	uded a language barrier and ia.			quarterly. Social Serwill assess resident to sensory impairments. Service Director will to	vice Directo o identify Social	<b>r</b>
	last revised on 2/23, communication rela	ted to: language barrier, inese." Approaches included,		4.	community referrals in obtain needed service residents.  Corrective action will	n order to es for	
	comprehension; rep gestures when nece with translation. 8. F encouragement if re communicate 10. newspapers/literature	eat when necessary. 4. Use ssary 7. Family to assist rovide reassurance and sident attempts to			monitored by Social S Director through resid quarterly care confere QI.	Service lent	

DEPAR	IMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		ILTIPLE CONSTRUCTION	(X3) DATE S	
٠		085012	B. WII				
NAME OF I	PROVIDER OR SUPPLIER	000012				· <u> </u>	5/2009
	CY HEALTHCARE & R	EHAB CENTER	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 250	Continued From page	ge 19	Ë:	251	50		
		are plan on 11/28/08)."		20			
	A social service not	e, dated 3/18/08, stated, " supportive, visiting often and		 			
	stated, " does not residents. + (positive	Record for R8, dated 5/29/09, interact c (with) staff or e) Language barrier- res. I 0 (no) English but is ncerns".					
	Communication Bar Residents ability to d	dated 6/25/09, stated, " rier interferes c (with) communicate needs". A NN, d, "Language Barrier ion problem".					
	R8 and R8 waved th (medication nurse as does not fully unders was difficult to know stated she believed I stated that staff com with hand signals, ie stated there was cur interpret for R8. E24 own ADL's, including to obtain information bowel movement wa worked in the facility	reyor tried to converse with e surveyor away. E24 ssigned to R8) replied that R8 stand English and stated it what she understands. E24 R8 was oriented and she municated with R8 mostly pointing to things. E24 rently no one in the facility to stated that R8 provided her toileting, but it was difficult such as when R8's last s. E24 stated she had about a year and wanted to mmunicate with R8, but there in place.					
-	7/24/09, E21 stated t because of the langu	vith E21 (activity aide) on hat although R8 was social, age barrier, R8 refused stated that activity staff					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					10/09/2009 APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		085012	B. Wil	√G		07/2	5/2009
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
REGENC	Y HEALTHCARE & R	EHAB CENTER		1	01 N. BROOM STREET /ILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 250	Continued From pa	ge 20	F	250			
	communicated with stated that 2 emplo Chinese; 1 fluently	R8 using hand gestures and yees on day shift spoke and the other a few words. It is no one to communicate with					-
	R8 on evenings or r						
	7/24/09. When asked visited, E26 and E2 they did not see any that R8 "likes to kee time she would fall a E27 stated that R8 first came to the fact talked much, but co asked how they wou wrong with R8 if she her needs, they repl for a few days at he the nurse to check I any devices to aid w E26 and E27 stated R8's room, however book (appeared bra pictures; E26 and E it before.	(CNA) were interviewed on ed how often R8's family 7 stated they did not know, but one on day shift. They stated up to herself' and most of the asleep in her room. E26 and was "more spunky" when she illity. They stated R8 neveruld say yes and no. When ald know if something was a was unable to communicate ied that if R8 did not get up rormal time, they would call R8. When asked if there were with communication for R8, no. When they searched, they found a communication and new) that included 27 stated they had never seen					
-	revealed R8 sleepin times of the day (mo sitting quietly on the of the nurse station	s from 7/20/09 to 7/24/09 g on top of her bed at various orning and afternoon) and/or couch in the lounge in front poking around. R8 was not atching TV or engaged in any survey.					
	got a Beijing website shared with R8. R8 I	trainer with the survey team on her laptop which she became excited and clapped sic and she actively read the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES							: 10/09/2009
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	——	TPLE CONSTRUCTION		. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL		. '	(X3) DATE S COMPLE	
	<u> </u>	085012	B. WIN	iĢ_		07/2	5/2009
NAME OF I	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	5/2005
REGEN	CY HEALTHCARE & R	EHAB CENTER		8	REET ADDRESS, CITY, STATE, ZIP CODE 301 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	TICK	1 0/6)
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION
TAG	REGULATOR) OR LA	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
- 250			1	لــيـ	DET TOTAL OF		
F 250		•	F 2	50			
	newspaper in Chine	ese.		.		er er	
						-	
	No family members	or visitors were seen during		1	-	•	
• •	the survey, although	h the facility identified in R8's		}			
	care plan and social	I services stated that R8's		•			
	family was to transla	ate.					
			1				
		ional meeting on 7/24/09, E9					
1		ted that the facility had					
1		anslators for multiple	ľ.		A Commence of the Commence of		
:		ed as needed. She stated that		.	· · · · · · · · · · · · · · · · · · ·		
ļ		nat the list was not being used					
	by staff for R8.		1				
	A Yelf and the day of the latter.	ا	1				
. I	Although the racility	identified and care planned	1 .	.		,	
	that Ro nad impaired	d communication and a		ļ.			
		ey failed to provide sufficient	1	:	ling of the second of the seco		
	and appropriate soc	cial services to improve R8's	-				
	Communication and	as a result, she was isolated.	1 1			* .	*.
	It Was unicidal writer	ner the communication book	1	1.	Barrier State Communication		
	howavor it was rink	room after the survey started, nown to staff interviewed that	1				
	nowever, it was utility	nown to start interviewed that   evice and a list of translators	r i				
	leveent for social se	ervice) existed for R8.	ı		Annual Control	٠.	
		services failed to provide	i				
	assistance related to	o activities of interest when	. ·				
		se newspapers and literature		1			Ì
		the facility in 11/08. Although					
	R8's family previous'	ly provided reading materials,		1			
	it is the responsibility	y of the facility to identify the					
	social service needs	of the resident and to assure		- !		. ,	
		net by the appropriate			at the state of th		•
	disciplines.			į		i	
		ONMENT- LIGHTING	F 25	56			
SS=D					•		
	The facility must prov						
	comfortable lighting I						
				ĺ		*	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTED	): 10/09/2009
CENTF	RS FOR MEDICARE	& MEDICAID SERVICES			1.	FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES					OMR NO	0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	LIBLE COM	ISTRUCTION	(X3) DATE S	
		BENTINGATION NOMBER:	A. BUILDI	NG .		COMPL	ETED
				_			
		085012	B. WING_	WING			25/2009
NAME OF	PROVIDER OR SUPPLIER		10-	DEET ADI	2000 000 000		20/2000
DEALL					DRESS, CITY, STATE, ZIP CODE ROOM STREET		
REGEN(	CY HEALTHCARE & R	EHAB CENTER			e e	\$	
<u> </u>	1		'	VVII IVIIIV	GTON, DE 19806	:	<u> </u>
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	· · · · · · · · · · · · · · · · · · ·	PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG		EACH CORRECTIVE ACTION SHOSS-REFERENCED TO THE API		COMPLETION   DATE
			170		DEFICIENCY)	PROPRIATE	L. DAIL
E 256	0 11 15		1	<del>!</del>			<del> </del>
F 256			F 256				
	This REQUIREMEN	IT is not met as evidenced				-	9/1/09
	by:						interest
	Based upon observ	ation, interview and record		F256			
	review the facility fa	iled to provide adequate and		1.	Maintenance Director of	checked	٠.
	comfortable lighting	levels for 2 residents (R39	1		both R39 and and R41		
	and R41). Findings	include:		•	lighting for actual need	s and	
				1	residents' preferences	for lighting	i
	1, R39 had diagnose	es including glaucoma and	,		The Maintenance Direct	etor	
	cardiovascular disea	ase. The annual Minimum			replaced the existing lig		
	Data Set Assessme	nt (MDS) dated, 3/9/09,			with higher wattage ligh	othulhe	· ,
1	coded R39's short a	nd long term memory as "OK"			Both residents were ex	amined by	
	and vision as visuall	y impaired. The quarterly		-	the Optomotrist and we	annineu by	
	MDS, dated 6/7/09.	continued to code R39's short	N. A.		assessed as having no		
-	and long term memo	ory as "OK". R39's care plan,			optical changes or addi		
	dated 3/10/09. for in	npaired vision/glaucoma			refraction needs. Mont	hly room	
	stated. "Maintain a s	afe environment at all times,			inspection report has be	oon	•
	adequate lighting"	are organization at all almos,			amended to include ligh	cell sting	1.
				<i>:</i> ·	preferences for all resid	lonto	
	On 7/20/09, during a	in interview, R39 stated that		. 2	All Residents have the	notontial	:
2	there is not enough	ight in her room to read		2.	to be affected by the de	potential	
,	books etc. The facil	ity failed to provide adequate			practice.	incient	
	additional lighting for	R39 in her room. On		2	Maintenance Director u	ndated	
	7/25/09, findings wer	re reviewed with the		. J.	present "Room Mainten	puated	
	administrative staff a	at the informational meeting.					
•		ar and importable and incoming.	,		Report". Room lighting		
			ļ		amended to include if lig satisfactory to resident's	gnung was	i .
	2. R41 was admitted	to the facility in 5/06 with			needs. Room Maintena	s visuai	
.	diagnosis that includ	ed cardiac dysrhythmia					
	hypertension period	eral vascular disease,			Report will continue to be	be used on	
.	cataracts and glauce	ma. The annual Minimum			a monthly basis.		
	Data Set Assessmen	nt (MDS) dated, 4/20/09,		4.	Corrective action will be		
	coded R41's short ar	nd long term memory as			monitored by Maintenar	100	
	"OK". The quarterly N	IDS dated 7/20/00			Director through Month!	укоот	•
	continued to code R4	11's short and long term			Maintenance Reports. I	keports	į (
1	memory as "Ok" □/	1's care plan, dated 7/31/08,	.		are kept by Maintenance	e Director	
· ] ;	for impaired vision of	ated, "Maintain a safe			in a series of room binde		
	environment at all tim	nes, adequate lighting"	ļ		findings will be reported	at	
.   '	on an oranion at all the	ics, adequate nymmy			Quarterly QI meetings.	. (	
	On 7/20/2009 and ad	ain on 7/24/2009 at 3:15 PM				1	
<b>'</b>	on meoreous and ag	am on 1/24/2009 at 3, 10 PM		•	-		

DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES		•		: 10/09/2009
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVED
STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII 7	FIPLE CONSTRUCTION		. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE S	
			A. BUILDIN	NG	30.00	
4		085012	B. WING_		y *	
NAME OF	PROVIDER OR SUPPLIER					5/2009
				REET ADDRESS, CITY, STATE, ZIP COD	DE .	
REGEN	CY HEALTHCARE & R	EHAB CENTER		BO1 N. BROOM STREET	*	
(V.0.10	CHRAIARN		\	WILMINGTON, DE 19806		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR	RECTION	(X5)
TAG	REGULATORY OR LE	SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE PPROPRIATE	COMPLETION
				DEFICIENCY)		
F 256	Continued From pa	ge 23	F 256	-		
100		R 41 stated his room is dark	1 200			اء امر
	and it was never tha	at way before. Observation of			-	10/15/09
	R 41 on 7/24/2009	evealed that the Left eye				
	appeared red and s	wollen. Interview with the		F279		÷ .
	Charge nurse (E5)	on 7/24/2009 at 3:40 PM		R63's antipsychotic c	are plan was	_
	revealed that she wa	as unaware that the resident		adjusted to indicated	side effects.	
	complained of the ro	oom being dark. E5 confirmed		Further care plans re	garding	
og til til e	that R 41 had almos	st no vision in his left eye. E5		anxiolytic use will be	updated as	
	spoke with the RNA	C (E28) and she confirmed		needed. R61's dialys	sis care plan	
	the decreased vision	n in R41's left eye. The facility		will be updated as ne	eded.	
	failed to provide ade	equate lighting for R41 in his		2. All residents have the	potential to	
	room. On 7/25/09, fi	ndings were reviewed with		be affected by deficie 3. Corrective actions inc	nt practice.	
	the administrative st	aff at the informational			lude DON	1
	meeting.		:	obtaining resident ant	ipsychotic	
F 279	483.20(d), 483.20(k)	(1) COMPREHENSIVE	F 279	and anxiolytic list from for RNAC. RNAC rev	n pnarmacy	
SS≓D	CARÉ PLANS			plans for listed reside	iseu care	
				specify antipsychotic/a	nts to opviolatio	
	A facility must use the	ne results of the assessment	· · ·	medications and each	anxiolytic	
	to develop, review a	nd revise the resident's		medication's individua		
- '	comprehensive plan	of care.		effects. AIMs testing	will be done	1
	Tha <b>f</b> ación	Sim Governor Selling		at admission (baseline	9	:
į	nian for each regider	elop a comprehensive care		assessment), upon sta	art of	
		nt that includes measurable		antipsychotic therapy,	and every	ĺ
	medical pureing an	ables to meet a resident's dimental and psychosocial		6 months after. The fa	acility	1 -
	needs that are identi-	fied in the comprehensive		devised an Interdiscipi	linary	
	assessment.	ned in the comprehensive	-	Dialysis Communication	on tool for	•
	accocomon.		·	use in resident status i	reporting	ļ
	The care plan must d	lescribe the services that are		between facility and di	alysis	_
	to be furnished to att	ain or maintain the resident's		center. The RNAC will	l revise all	
	highest practicable p	hysical mental and		resident anxiolytic and	dialysis	
	psychosocial well-be	ing as required under		care plans to reflect me	edication	* .
	§483.25; and any ser	vices that would otherwise	Ì	side effects and the dia	alysis	
•	be required under §4	83.25 but are not provided		communication as nee	ded. DON	
-	due to the resident's	exercise of rights under		obtained behavior shee	ets and	
	§483.10, including the	e right to refuse treatment	-	placed on MAR's for nu	ırse	
	under §483.10(b)(4).		. :	monitor. Staff Educato	or will in-	.
			!	service on AIMs testing	g, Behavior	
		in the second of the second of the		sheets, and Interdiscip	linary	
	<u></u>		1.	Dialysis Communicatio	n tool.	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					0: 10/09/2009
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			···		APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		- 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			SURVEY ETED	
		085012	B. WING	3		07/:	25/2009
NAME OF F	PROVIDER OR SUPPLIER		S	STRÉET	ADDRESS, CITY, STATE, ZIP CODE		
REGENO	CY HEALTHCARE & R	EHAB CENTER			BROOM STREET		•
				WILM	IINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 24	F 27	79	DON will continue to provi	do	
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	This REQUIREMEN	NT is not met as evidenced		_	RNAC with a pharmacy lis month of residents on	t each	
	by: Based on record re	views and staff interviews, it			antipsychotics and anxioly	fice to	4 .
	was determined that	it the facility failed to ensure			ensure proper care plannir	ກດອຸເດ ການ	
		care plans were developed	ļ		DON will obtain a list of res	sidents	
era e de la composición dela composición de la composición de la composición dela composición dela composición dela composición de la composición dela composición de la composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela composición dela	for 2 residents (R61	and R63) that addressed the		-	on antipsychotics from pha	rmacv	
	residents' nursing n	eeds. Although the facility			for staff to ensure baseline	s and	
	care planned for the	e potential for psychotropic	•.		q6 month monitoring of AIN	/Is are	
• .•		fects related to taking the			completed. Unit Managers	on	
	antipsychotic (Sero		. 11		both nursing floors will mor	itor	
	failled to list specific	medications for R63, they side effects (including			return receipt of forms and resident's chart. All staff w	tile on	<u>'</u>
		o these medications, they	,	·	in-serviced on the Interdisc	III DE. inlinen:	
		v they were going to monitor		-	Dialysis Communication to	J hiiitai A	
<i>.</i>		d side effects of the		4.	Corrective actions will be		
		ey failed to list lesser			monitored by the following:		
	alternatives (non-dr	ug interventions) before	į.		RNAC will monitor care plan	ns	
	administering Ativar	n, Additionally, the facility			quarterly at MDS generation	n to	
	failed to perform an	AIMS (Abnormal Involuntary		1			
	Movement Scale) te	st when R63 was started on		,	ensure proper care planning	of	
	information recording	llysis care plan lacked			antipsychotics, anxiolytics, a	ind	
		g the coordination of services and the dialysis center.	-		dialysis communication tool.	Unit	
	Findings include:	and the dialysis center.			Managers will ensure q6mor completion of AIMs prior to	าเท	
	and the second s	•			resident care conference pe	r liet	
	1. Diagnoses for Re	33 included end stage	,		of weekly MDS's to be gene	rated	
	dementia with a mod	od disorder and blindness.			by RNAC. Unit Managers wi	II	
		ician order sheet) revealed			monitor for proper Behavior	sheet	
-	that R63 received S	eroquel (antipsychotic) 25 mg			documentation on a weekly I	basis.	
	twice a day and Ativ	an (antianxiety) 1 mg every 6		·	improper documentation (All	Ms	
	ordered on 5/26/09.	agitation/aggression that was			and Behavior sheets) by nur	sing	<u> </u>
-	ordered on bizolog,				staff will be reported to the D	ON	
	Care plans were dev	veloped on 6/1/09 for the			for follow up with the individu	ial .	
		ropic drug-related side effects	•		staff member. Staff Educator maintain in-servicing records	WIII	
		psychotic and anxiolytic	٠		the Interdisciplinary Dialysis	, UH	
	medications. Approa	ches listed on the care plan			Communication tool.		
	included, "1. Medica	te per MD order and	•	-			!
	monitor for affective	sees and side offeets of			•	•	:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  (X3) DI  NAME OF PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  (X4) ID  PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 279  Continued From page 25 medication 4. Monitor and document signs/symptoms of adverse effects as well as positive effects from the drug. These approaches were generic; the facility failed to list specific side effects (including behaviors) related to the medications and they failed to identify how they were going to monitor for effectiveness and side effects of the medications.  Review of the anxiolytic care plan additionally listed the approach, " 7. Explore ways to eliminate anxiety with resident" An annual MDS (minimum data set) assessment, dated 2/28/09,			MEDICAID SERVICES				M APPROVED 0. 0938-0391	
NAME OF PROVIDER OR SUPPLIER  REGENCY HEALTHCARE & REHAB CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. BROOM STREET WILMINGTON, DE 19806  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 279  Continued From page 25 medication 4. Monitor and document signs/symptoms of adverse effects as well as positive effects from the drug. These approaches were generic; the facility failed to list specific side effects (including behaviors) related to the medications and they failed to identify how they were going to monitor for effectiveness and side effects of the medications.  Review of the anxiolytic care plan additionally listed the approach, " 7. Explore ways to eliminate anxiety with resident" An annual MDS (minimum data set) assessment, dated 2/28/09,	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/O		1) PROVIDER/SUPPLIER/CLIA	1, ,	· · · · · · · · · · · · · · · · · · ·	(X3) DATE COMPL	SURVEY	
REGENCY HEALTHCARE & REHAB CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. BROOM STREET WILMINGTON, DE 19806	-		085012	B. WINC	3	07/	25/2009	
REGENCY HEALTHCARE & REHAB CENTER  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 279  Continued From page 25 medication 4. Monitor and document signs/symptoms of adverse effects as well as positive effects from the drug. These approaches were generic; the facility failed to list specific side effects (including behaviors) related to the medications and they failed to identify how they were going to monitor for effectiveness and side effects of the medications.  Review of the anxiolytic care plan additionally listed the approach, " 7. Explore ways to eliminate anxiety with resident" An annual MDS (minimum data set) assessment, dated 2/28/09,	NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS CITY STATE 7:P		2312003	
(X4) ID PREFIX TAG    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    F 279	REGENCY	HEAI THOADE & DEU	AR CENTED			0002		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 279  Continued From page 25  medication 4. Monitor and document signs/symptoms of adverse effects as well as positive effects from the drug. These approaches were generic; the facility failed to list specific side effects (including behaviors) related to the medications and they failed to identify how they were going to monitor for effectiveness and side effects of the medications.  Review of the anxiolytic care plan additionally listed the approach, " 7. Explore ways to eliminate anxiety with resident" An annual MDS (minimum data set) assessment, dated 2/28/09,		TEACHIOANE & NEH	AD CENTER		WILMINGTON, DE 19806			
medication 4. Monitor and document signs/symptoms of adverse effects as well as positive effects from the drug. These approaches were generic; the facility failed to list specific side effects (including behaviors) related to the medications and they failed to identify how they were going to monitor for effectiveness and side effects of the medications.  Review of the anxiolytic care plan additionally listed the approach, " 7. Explore ways to eliminate anxiety with resident" An annual MDS (minimum data set) assessment, dated 2/28/09,	PREFIX	(EACH DEFICIENCY MU	JST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
medication 4. Monitor and document signs/symptoms of adverse effects as well as positive effects from the drug. These approaches were generic; the facility failed to list specific side effects (including behaviors) related to the medications and they failed to identify how they were going to monitor for effectiveness and side effects of the medications.  Review of the anxiolytic care plan additionally listed the approach, " 7. Explore ways to eliminate anxiety with resident" An annual MDS (minimum data set) assessment, dated 2/28/09,	F 279	ontinued From page	25	E 2	70	· · · · · · · · · · · · · · · · · · ·	<del></del>	
and quarterly MDS, dated 5/29/09, stated R63 had severe cognitive impairment, short and long-term memory impairment, and communication problems. R63 was not capable of exploring ways to eliminate anxiety. The facility failed to identify and list ways in which to reduce and/or eliminate anxiety for R63 and they failed to		nedication 4. Monitorigns/symptoms of advositive effects from the vere generic; the faciliffects (including behaved and they force going to monitor effects of the medication eview of the anxiolytic sted the approach, " iminate anxiety with reminimum data set) as and quarterly MDS, data disevere cognitive in ng-term memory important problem exploring ways to elicited to identify and lis	or and document verse effects as well as the drug. These approaches ity failed to list specific side eviors) related to the failed to identify how they for effectiveness and side ons.  c care plan additionally. 7. Explore ways to resident". An annual MDS sessment, dated 2/28/09, ted 5/29/09, stated R63 in airment, and ms. R63 was not capable minate anxiety. The facility t ways in which to reduce		79			
list lesser, non-drug interventions to consider/use before administering Ativan to R63.  Findings were confirmed with E4 (Unit Manager) and E22 (Medication Nurse) on 7/23/09. E4 stated the only place behaviors were documented are on ADL flow sheets (completed by CNA's) and on the back of the Ativan medication administration record. Additionally, interviews with E2 (Director of Nursing) and E4 confirmed that the facility failed to perform an AIMS (Abnormal Involuntary Movement Scale) test when Seroquel was started on 5/26/09. They stated it was facility practice (confirmed in review of the facility AIMS testing policy) to do it 6 months after an antipsychotic was started and every 6 months thereafter; their practice did not include a baseline AIMS test. The facility failed to have a baseline AIMS test when R63's Seroquel was started on	li bi Fassa a a Ett ir w p te a tr A	at lesser, non-drug interfore administering Aller administering Aller administering Aller and E22 (Medication Nated the only place been ADL flow sheets and on the back of the aller aministration record. Aller actions of Nursing a facility failed to perform the started on 5/26/09 actice (confirmed in resting policy) to do it 6 tipsychotic was started ereafter; their practice MS test. The facility for the started on the star	erventions to consider/use tivan to R63.  ed with E4 (Unit Manager) urse) on 7/23/09. E4 ehaviors were documented to (completed by CNA's) Ativan medication Additionally, interviews with and E4 confirmed that form an AIMS (Abnormal Scale) test when Seroquel. They stated it was facility eview of the facility AIMS months after an ed and every 6 months ed did not include a baseline ailed to have a baseline					

		I AND HUMAN SERVICES & MEDICAID SERVICES					FORM	10/09/2009 1 APPROVED 1. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		PLE CONST	RUCTION	(X3) DATE SURVEY COMPLETED		
		085012	B. WII	NG_	<del></del>		07/25/2009	
NAME OF I	PROVIDER OR SUPPLIER			STF	REET ADDRE	SS, CITY, STATE, ZIP CODE		
REGENO	CY HEALTHCARE & R	EHAB CENTER	•			OM STREET ON, DE 19806		
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F 279	Continued From pa	ge 26	F	279				
	5/26/09 so that a comonths later to ass 2. R61 had a diagno	omparison could be made 6 ess for any changes. osis of renal failure and sis at an outside dialysis		-10				
	Failure", last update approaches, includi dialysis center), Day care plan lacked ap of services between center. Additionally approaches for mor	are Plan titled, "Dialysis/Renaled on 3/17/09 listed tening "10, Dialysis at: (name of ys and time: T-Thur-Sat." The proaches for the coordination the facility and the dialysis, the care plan lacked after dialysis treatments.						
F 280 SS=E	care plan for R61's addressed the coord the facility and the d acknowledged by th informational meeting	develop a comprehensive dialysis treatments that dination of services between lialysis center. Findings were administrative staff at the ng on 7/24/09.  O(k)(2) COMPREHENSIVE	F 2	80	F280			10/1/09
	The resident has the incompetent or othe incapacitated under	the laws of the State, to ng care and treatment or		The state of the s	1.	Corrective actions for care plan updating by Director to activity car including: - Daily "Meet and Gree (schedule of daily actions are used will be provided).	Activity e plan et" vities and	
	within 7 days after the comprehensive asset interdisciplinary team physician, a register for the resident, and disciplines as determined to the resident of th	are plan must be developed ne completion of the essment; prepared by an n, that includes the attending ed nurse with responsibility other appropriate staff in nined by the resident's needs, acticable, the participation of				menus) will be provide Chinese. Staff will revesident each morning encourage resident to group activity she wou attend. Staff will follow invite to stated activity document participation daily.	view with g and choose 1 uld like to w up with and	S

daily.

DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES			· · · · · · · · · · · · · · · · · · ·	EUDW KKIIN LED	APPROVED
		& MEDICAID SERVICES					. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N	IULTII	PLE CONSTRUCTION	(X3) DATE S		
7.0.0 7.0.00	IDENTIFICATION NUMBER.		A. BU	ILDING	G	COMPLE	=1EU
_	-	085012	B. WII	VG	<u>-</u>	07/2	5/2009
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
REGENO	Y HEALTHCARE & R	EHAB CENTER		1	01 N. BROOM STREET /ILMINGTON, DE 19806		
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F 280	Continued From pa	ae 27	F :	280			
	_ = = : : : : = = = = = : : • • · · · · · · · · · · · · · · · ·	sident's family or the resident's		200	- Use phone translator, residen		
•	legal representative	e; and periodically reviewed		: [	family, and two staff members		
,		am of qualified persons after			(staff educator and 3-11 C.N.A	.)	
	each assessment.	ziii oi qualiiloa poitootio aitoi			as needed to translate for		-
	 				resident and staff to aid in clea	rer	
					communications.		3.7
					- Connect resident with		
					community organizations/churches with		
	This REQUIREMEN	NT is not met as evidenced	14	.	members from native country v	vho	
	by:			.	speak native language.	VIIO	
		view and interview it was			- Family to provide resident wit	h	
		facility failed to review and			publications of native language		
		r 7 sampled residents (R8,			for daily reading or as desired		
÷		3, R75, and R84). Findings		٠.	resident.	<b>.</b> ,	
	include;				- Provide videos,		1.1
			•	-	documentaries/movies of nativ	e l	
	cross-refer F221	The second second			language weekly or as desired		
	1. Review of R63's (	care plan for side rails, dated		1	resident to watch independent		
		ated 7/16/09, stated,	1.7		in room. Use Netflix as primar		
		ested to use a side rail for		.	resource. A DVD player was		-
		bler to promote independence		- 1	purchased for resident.		
	Approaches include	ate in his/her own care". d, "1. Patient will fill out and		.	Corrective actions for R20		
		ent Form 3. Continued			include:		
		the safe use of side rails and		.	<ul> <li>Activity Director is now attended</li> </ul>	ling	
		alternative devices instead".		.	daily clinical meeting to be		
		anomativo dovidoo motoda			informed of any significant		
	R63 had end stage	dementia and blindness. An		.	change in resident status that		<u> </u>
		um data set) assessment,			potentially could affect leisure	!	
		quarterly MDS, dated 5/29/09,		ļ	participation.		
		ere cognitive impairment,		-	- Care plans will be updated ar		
		memory impairment, and		.	revised on quarterly basis or w	TUTI (,	
		olems. R63 was not capable		. [	significant change by Activity		
	of requesting side ra	ails, signing a consent form, or			Director Activity Director will hold daily		
	remembering patien	t education.			meetings with activity staff to		
				. :	discuss any change in resident	te'	1
		sessments, dated 3/3/09 and 📜			status regarding activity	i.o	
		10. Has the resident		i	participation		
	expressed a desire t	to have side rails while in		Ţ,	participation		

#### PRINTED: 10/09/2009 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 085012 07/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. BROOM STREET **REGENCY HEALTHCARE & REHAB CENTER** WILMINGTON, DE 19806 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 280 Continued From page 28 F 280 Communication book was bed? N (no)... At this time, side rails are indicated eliminated. Speech therapist per family request...". Family interview on 7/23/09 designed a Chinese confirmed that the family requested the side rails communication board with a few years ago and confirmed that R63 had not pictures for resident. Social been able to use the rails for positioning/as an Worker posted in resident's room enabler for a long time. and staff were in-serviced on use of Chinese communication board. Findings were reviewed during the informational R13's care plan was updated to meeting on 7/25/09. reflect need for properly fitting dentures and plan for obtaining cross-refer F248 dental services. Resident has a 2a. Review of R8's care plan for communication, dental appointment on dated 7/23/08 and last updated 2/23/09, stated. 10/29/2009, R20 was discharged "... has impaired communication related to: to home with family/caregiver, language barrier, resident speaks: Chinese." R41's care plan was adjusted to Approaches listed included, "... 4. Use gestures reflect use of interdisciplinary when necessary... 7. Family to assist with communication tool for translation. 8. Provide reassurance and information reporting by dialysis encouragement if resident attempts to to nursing home, R63's care plan communicate..." was changed to reflect side rail use for turning and repositioning A Nurses' Note (NN), dated 6/25/09, stated, ".... and to increase resident's sense Communication Barrier Interferes c (with) of safety and security per request Residents ability to communicate needs...". A NN, of daughter, R75's care plan was dated 7/16/09, stated, "... Language Barrier updated to reflect eye exam and creates communication problem..." findings with standard nursing care and Restorative nursing with E24, a medication nurse, stated she believed R8 use of MAFO for ambulation, and was oriented and that staff communicated with R84 has been discharged to the R8 mostly with hand signals, i.e.- pointing to hospital. things. E24 stated there was currently no one in the facility to interpret for E8.

E27, a CNA, and E28, a CNA, were interviewed on 7/24/09. When asked how often R8's family visited, E27 and E28 stated they did not know, but they did not see anyone on day shift. When asked

communication for R8, E27 and E28 stated," no".

if there were any devices to aid with

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Cross refer to F 325

3. R 84 was admitted on 2/17/2009 with diagnosis which included hypertension, schizophrenia, emphysema and cancer. On the 7/20/2009 the

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F 280	Continued France	20	·				
. 1 200		· 1	F 2	280		-	
	physician's history a	and physical included the		. ]	(eyes, hearing,		
	diagnosis of brain a	ineurysm, anxiety and pain.			communication/language,	dental)	
				l	care plans at resident quar		
					care conference and alert	Social	
	The facility develop	ed a care plan for alteration in			Services of any needs not		
	nutrition and hydrat	ion dated 2/20/2009 and	in the second	1	addressed and needing att		
		99 and 7/24/2009. This			RNAC will audit for proper		
		o significant weight loss	44.		planning of activity care pla	ans at	
		, and weight to remain above			quarterly resident care		
1 -					conferences and alert Activ		
	145 pounds. The ap				department of any needs n	ot	
-		lered, med pass 4 ounce three		}	addressed and needing att	ention.	
		ences obtained, sandwiches	•		RNAC will audit for proper	care	1
		ument on MAR. Under			planning of nutritional care	plans	
		cian wrote on 7/24/2009 weight			at quarterly resident care	•	
		monitor at high risk. While the			conference and alert Dietic	ian of	
		periods when the resident lost			any needs not addressed a		
		entify the 7.8% weight loss in			needing attention. Follow		
4.	3 months. Additiona	ally the complete care plan			care plan revisions will be		
	failed to mention or	identify the resident's			by RNAC as needed and F		
	diagnosis of COPD	and how that would impact on		]			ŀ
	R84's caloric require				will address any outstandir		
					planning needs with specif		٠.
	41 at 1				interdisciplinary members	iO .	
	Cross refer to F 250	6 example #2	Ē		remedy.	i	-
		d to the facility in 5/06 with	-	-			
		ded cardiac dysrhythmia					
		neral vascular disease,					
		oma. While the facility					
		an for R41's dated 7/31/08					
		t failed to be revised to include					
1	i i	R41 had almost no vision in					-
1	his left eye.				and the second s		
.							
		41 had almost no vision in his		j			ì
		rith the RNAC (E28) and she		į			
		ased vision in R41's left eye.		1	•		1
		review and revise the care			- ·		
.	plan to include this in	nformation. On 7/25/09,					

#### PRINTED: TUTUSIZUUS DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 085012 07/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. BROOM STREET REGENCY HEALTHCARE & REHAB CENTER WILMINGTON, DE 19806 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 31 F 280 findings were reviewed with the administrative staff at the informational meeting. 5. R20 was admitted to the facility on 6/17/09 with diagnoses of stroke affecting her left side and mental retardation. On 7/14/09, R20 fell out of bed and fractured her left humerus (Upper arm/shoulder). R20's Activity Care Plan, dated 6/26/09, had a plan of action including group activities on and off unit, encourage independent activity such as watching TV, provide reading materials. The Initial Assessment for Activities, dated 6/26/09, listed current interests as games including Bingo and Pokino, crafts, exercise, music, reading, watching TV, and talking. Multiple observations were made on 7/20, 7/21 and 7/23 of R20 laying awake in her bed, without the TV on, books to read, or listening to music. On 7/24/09, an interview with E21 revealed that the facility had not revised the Activities Care Plan for R20 in light of her fracture to provide any additional appropriate activity interventions.

informational meeting.

The facility failed to revise the Activity Care Plan as R20's status changed. On 7/25/09, findings were reviewed with the administrative staff at the

6. R75 was readmitted to the facility on 4/21/09 with diagnoses including Alzheimer's Disease, depression and cardiovascular disease.

A significant change Minimum Data Set (MDS) Assessment, dated 4/28/09, coded R75's

		I AND HUMAN SERVICES			FORM APPROVED
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F 280	Continued From pa	ge 32	F 280		
,	personal hygiene as one person assist a help of one person.	s extensive assistance with nd coded bathing as physical			
	On 7/20/09 and 7/23 of R75 with fingerna under them.	3/09, observations were made alls that were long with dirt			
	dated 5/8/09, to spe 7/25/09, findings we administrative staff a Cross refer to F411 7. Observations of F from 7/20/09 throug had no top teeth. To on his bedside table R13 on 7/21/09, he	revise the ADL care plan, soify nail care for R75. On the reviewed with the at the informational meeting. R13 throughout the survey, h 7/24/09, revealed that he op dentures were observed. During an interview with stated that he could not wear ce they no longer fit properly.			
	the resident had his "dentures to top." T care plan that the re	ental" care plan revealed that own bottom teeth and here was no indication in the sident did not wear his top fact that they no longer fit him			
	plan to indicate his refitted. Findings we administrative staff a on 7/24/09.	revise R13's "Dental' care need to have his top dentures ere acknowledged by at the informational meeting	F 311		
	services to maintain	ne appropriate treatment and or improve his or her abilities oh (a)(1) of this section.			

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		& MEDICAID SERVICES			OMB NO. 0938-039
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F 311	This REQUIREMENthy: Based upon observed review, it was determined appropriate maintain or improved resident (R75). The when an orthotic decrease. Findings including the foot orthos for foot drop.  Observations made revealed that the analytic half of the stand a Additionally, on 7/23 she walked R75 to a server review.	ation, interview and record mined that the facility failed to treatment and services to abilities for 1 sampled facility failed to follow up vice arrived which R75 was to	F 311	1. R75 was seen by the Occupational Therestate Survey. R75 Restorative Nursing perform lower extres with a #3 weight, but to do sit to stand to ambulate 15 with single point cat to left foot.  2. All residents who resorthotic have the positive affected by the defiected by the defiected by the residents will obtain order from and then place orded device. Therapists all orthotic devices.	apist during the was placed on g Services to emity exercises lue theraband, ansfer training, 60-200 feet ne and MAFO equire an otential to be cient practice. ess resident for rthosis is dent, therapist m physician er for orthotic will do this for Any orthotics
	On 7/23/09, during a Assistant Director of orthotic was fitted or approximately on 6/2 a nurse's note, dated was in place. Howev documentation of us On 7/23/09, E5 the Lat the facility failed orthotic arrived with schedule supplied by Additionally, on 7/23, Occupational Therag	Unit Manager, acknowledged to follow through after the proper use and a breaking in the orthotic company.		ordered by an outsi physician will be rep Unit Nurse Manage further follow up and All resident orthotics delivered, will go to Therapy for assession of care/treatment. A found delivered to the room, and not the treapy department possible for further extreatment by therapy Therapists will in-se	ported by the r to therapy for d monitor. s, ordered and Physical ment and plan Any orthotics ne resident nerapy taken to the as soon as evaluation and ists.

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F 311	Continued From page	gë 34	F	311	staff when an orthotic devi	ico is	
		4/09, E7, the Physical Therapy	' `	211	ordered for a resident.	CC 13	
	Area Manager ackr	nowledged that he was calling			4. Corrective action will be	_	
,	the company to have	e all orthotics delivered	i .		monitored by the therapy		
1	directly to the Physic	cal Therapy (PT) Department			department (Physical and	or	
	so that they would b	e assessed for proper fif by		. :	Occupational) for ordered	UI,	
.:	both the company o	roviding it and the facility PT	İ		orthotics follow up as appr	conrioto	
	Department F7 also	stated that R75's orthotic did	:		for receipt by the facility.	opnate	
	not fit properly and t	he company would have to			tor receipt by the racinty.		
	adjust it.	ne company would have to					5
	T THE TEXT		·				
	The facility failed to	provide appropriate services					
	to maintain R75's at	illities related to his left foot	N				
	drop by failing to foll	ow through when the orthotic		.		<u>.</u> *	
	for R75 was delivere	d in June. Findings were					
	acknowledged by Es	, E6, and E7 between					al I
	7/23/09 and 7/24/09	, 20, and 2, 50th 50h					10/1/09
F 312		TIES OF DAILY LIVING	F3	12	F312	: : <del>:</del> '	
SS=D		7,200, 0, 0,21	į v	12			1.
:	A resident who is un	able to carry out activities of	1. 1. 1		R75 was given nail ca	re upon	
	daily living receives t	he necessary services to	-	j	learning of deficiency l	DON DON	
	maintain good nutriti	on, grooming, and personal			and Unit Nurse Manag	er.	
	and oral hygiene.	and Statement State Research			2. All residents have the	potentiai to	)
. ]	The second of the second				be affected by the defi- practice.	cient	
				·		"	
				.	i i jaiono i commonan	position	
	This REQUIREMEN	T is not met as evidenced			has been created and implemented by Septe	wiii de tully	'
	by:	en en en en en en en en en en en en en e			2009 One took will be	mper 15,	
		n, interview and record		İ	2009. One tech will be shift and one tech will be	: on the 7-3	5
	review it was determ.	ined that the facility failed to			3-11 chiff The byeins	took=:-:	
	provide necessary se	ervices for 1 sampled			3-11 shift. The hygiene will be a C.N.A. respon	riechnician	
	resident (R75) who re	equired assistance with		.	showing and bathing a	olivitics	h
	activities of daily livin	g (ADLS). The facility failed			and nail care. On resid	Juvilles, lent's	
	to provide nail care for	or R75. Findings include:			scheduled shower day,	Hydions	
.					tech will clean and cut i	riygiene	1.
	R75 was readmitted	to the facility on 4/21/09 with		. !	appropriate. Unit Mang	idiis as	
	diagnoses including /	Alzheimer's Disease,		٠.	address with hydians to	icis Will	
	depression and cardi	ovascular disease. A			address with hygiene to residents should not ha	con which	
	significant change Mi	nimum Data Set (MDS)	-		clipped related to disea	ve nails	
J.	Assessment, dated 4	/28/09, coded R75's		1	process (i.e. diabetes).	> <del>C</del>	
				;	process (i.e. ulabetes).		ŀ

		I AND HUMAN SERVICES  & MEDICAID SERVICES					APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY	
		085012	B. WIN	VG		07/2	5/2009
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CO	DDE	
REGENO	CY HEALTHCARE & R	EHAB CENTER			01 N. BROOM STREET VILMINGTON, DE 19806		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 35	E.	312	4 Corrective action will	he	
	1	s requiring extensive		J 12	monitored by the DO	,	
		person assist and coded			and Unit Nurse Mana		
		the physical help of one			Hygiene tech will mo		
· . '	person.				care need on a biwe		
			*.	.	Hygiene tech will har		
		3/09, observations were made			Nurse Manager an c		
		ails that were long with dirt			the end of shift to inc residents received c		
s en en	under them.				residents refused ca		
	The facility failed to	provide nail care to R75, a	2.4		is still needed. The		
		ed assistance with ADLS. In		٠.	Manager will then fo		
14		3/09, E3, the Assistant		., .	indicated to assure t		
		(ADON), acknowledged that			hygiene is given to t		
		ng and dirty. E3, the ADON,	-				
13		s, a CNA, had provided nail					
	care to R75 after it very by the surveyor.	was brought to their attention					9/30/09
F 313	483.25(b) VISION A	ND HEADING		313	F313		1. 1.
SS=D	400.20(b) VIOIQIV	WAS LICARUNO		יייי	1. R75 has been reso	cheduled for	
با – ريان	To ensure that resid	lents receive proper treatment		5	cataract surgery 9/		ja s
		es to maintain vision and	_		has had an eye ex	am paid for by	
P 4		e facility must, if necessary,			the facility. Result		
		n making appointments, and			for glaucoma treat		
		isportation to and from the			follow up appointm		
		er specializing in the			All residents have be affected by the		
		or hearing impairment or the nal specializing in the	•	• •	practice.	dendent	
		r hearing assistive devices.			Social Service Dire	ector developed	<b>d</b>
	p, - 1, - 1, - 1, - 1, - 1, - 1, - 1, -	, , , , , , , , , , , , , , , , , , , ,	•		a Sensory Assess		_
					will conduct a	* * * * * * * * * * * * * * * * * * * *	2
	This REQUIREMEN	IT is not met as evidenced	· · ·		vision/hearing/den		t ;
	by:	<u> </u>			of all residents with		
		w and record review it was			days of admission/		•
		facility to follow up to provide for 2 sampled residents (R75			and quarterly and t scheduled appoint		
	and R90). Findings		:		nursing.	nens, done by	'
٠.	and resoj. I munigs	inolade.	3		4. Corrective action w	vill be	
	1. On the significant	change Minimum Data Set	-		monitored at reside		
		dated 4/28/09, R75 had			care conferences a		

CENTE	IMENT OF HEALTH RS FOR MEDICARE	HAND HUMAN SERVICES  8 MEDICAID SERVICES					1 APPROVED . 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	JLTIPLE CONST	FRUCTION	(X3) DATE S COMPLI	SURVEY
· <u>.</u> · ·		085012	B. WING			07/2	25/2009
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRI	ESS, CITY, STATE, ZIP CODE		.012000
REGEN	CY HEALTHCARE & R	EHAB CENTER		801 N. BRO	OM STREET ON, DE 19806	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORR ICH CORRECTIVE ACTION SI SS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 313	Continued From page	ge 36	F 31	13			
Sec. 2	The state of the s	g cataracts and glaucoma.					
	cataract surgery cor appointment was ca	ohysician wrote an order for a nsult. When the initial ancelled in April 2009, the chedule the appointment.					
	Director of Nursing of that the facility failed cataract surgery cor 2. Resident R90 had Assessments (MDS 2/15/2008 indicating highly impaired. A s	d Minimum Data Set 6) dated 5/20/2008 and g that this resident's vision was subsequent MDS assessment licated that the resident's					
	that a vision appoint the optometrist but, hospice approval fo On 7/23/2009, in an	ote dated 3/23/2009 indicated the three was a need to obtain or payment.  Interview with E9, the Social he acknowledged that the					
	facility failed to follow they would pay for the appointment could be	w up with hospice to inquire if he optometrist so an pe scheduled.					9/15/09
F 318 SS=D	483.25(e)(2) RANGE	É OF MOTION	F 31	18 <b>F318</b>	P01 was asset 11		•
	resident, the facility r with a limited range of appropriate treatmen	nt and services to increase /or to prevent further			R91 was assessed to Occupational therapy State Survey visit an ROM and splinting, given an treatment pulaced on Restorative ROM and splinting. All residents have the be affected by this design of the ROM and splinting.	ist during nd trialed for Resident was lan and e Nursing for e potential to	<b>r</b>
					practice.	MOIGHE	

		& MEDICAID SERVICES			FORN OMB NO	1 APPROVED 2. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mt A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	SURVEY
		085012	B. WIN	G	07/2	25/2009
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
REGEN	CY HEALTHCARE & R	EHAB CENTER		801 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	V SHOULD BE	(X5) COMPLETION DATE
F 318	This REQUIREMENT by: Based upon intervier review it was determensure that one restrange of motion rectand services to increase fundings include: Resident R91 was crange of motion of Resident interview at that resident R91 has which effected the learm and hand. While assessment, dated R91's ambulation are the facility failed to that resident R91 rectand services to increase funding the digits on his left. The facility failed to that resident R91 rectand services to increase funding the digits on his left. The facility failed to that resident R91 rectand services to increase funding the digits on his left. The facility failed to the digits on his left. The facility failed to the digits on his left. The facility failed to the resident R91 rectand services to increase funding the facility must ensenvironment funding as is possible; and experience and services to increase funding the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains as is possible; and experience for the facility must ensenvironment remains and the facility must ensenvironment remains and the facility must ensenvironment remains and the facility must ensenvironment re	w, observation and record and that the facility failed to sident (R91) with a limited eived appropriate treatment ease range of motion and/or ecrease in range of motion.  Abserved as having limited the digits on his left hand, and record review revealed at a stroke in December 2008 eff side functioning of his left ethe rehabilitation 1/1/2009, addressed resident and left arm range of motion, address range of motion of hand.  Assess, care plan and ensure the ceived appropriate treatment ease range of motion and/or crease in range of motion of the treatment and suppropriate treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease in range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range of motion of the treatment ease range ease the treatment ease range ease the treatment ease range ease ease ease ease ease ease ease ea	F 32	3. Occupational theraping ROM on all residents for an MDS by RNAC Occupational theraping section G3 and determine for plan of care for Rothrough further skilled or Restorative nursing Occupational therapy determine need for sporthotics.  4. Corrective action will monitored by RNAC to coding of ROM on ME assessment (G3) and care plans at resident care conference. ROI care and treatment will monitored by Occupational therapist and Restorational therapy referring and monthly by RNAC generation of Function Summaries. Weekly RNI Nursing meetings will at Quarterly QA.	scheduled c: st will code mine need DM, either d therapies g. will blints and be hrough DS review of quarterly M plan of li be tional tive Nurse als weekly through al Care Restorative	
	This REQUIREMEN'	Γ is not met as evidenced				
<del></del> 1				_ !		; L

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/09/2009 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATÉ SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 085012 07/25/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 801 N. BROOM STREET **REGENCY HEALTHCARE & REHAB CENTER** WILMINGTON, DE 19806 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAĞ DEFICIENCY) F 323 Continued From page 38 F 323 F323 Based on record review, observation and DON and Unit Nurse Manager interview, it was determined that the facility failed both spoke with the responsible to ensure that 1 sampled resident (R63) remained party (daughter) for R63 and free from accident hazards. R63 had diagnoses determined risks vs. benefits of including end stage dementia and a mood side rail use. Daughter requested disorder with behaviors, including repetitive arm continuation of side rails use for movements and resistance to care. It was known use as an enabler for turning and to the facility that R63 had a history of hitting the repositioning and to increase side rails on the bed and removing the bolsters resident's sense of safety and (long, narrow cushion in place to pad the side security. Resident holds onto the rails). R63 sustained a finger fracture on or about side rail during incontinency 4/23/09 and an x-ray revealed "acute changes. Unit Nurse Manager osteoporosis" of the finger, yet full side rails and obtained signed consent for side bolsters remained in place. The rails, ordered for rail use, and obtained physician safety and as enablers had not been utilized by order for side rail use. RNAC R63 as enablers for a long time due to updated care plan to reflect side deterioration of her dementia. Facility rail use as an enabler for turning assessments on 3/3/09 and 6/2/09 confirmed that and repositioning and to increase R63 did not have a medical condition that resident's sense of safety and required side rails nor were they indicated or security at the request of the served as enablers to promote independence. resident's daughter/responsible The facility also failed to have PT/OT screenings/evaluations for appropriate use of the All residents have the potential to side rails/alternative devices. The facility failed to be affected by the deficient recognize that the side rails had become an practice. accident hazard for R63, yet they remained in 3. ADON and Unit Nurse Managers place. The facility also failed to have side rail are conducting facility wide care plan interventions that were current to R63's assessment of all residents to present situation. Additionally, there were electric determine risk versus benefits of wheelchairs being charged incorrectly in the side rail use in individual hallways which posed an accident hazard. residents and assuring all Findings include: appropriate consents and orders are in place on residents' charts. Cross refer F221, example #1 Electric wheelchairs will be 1. R63 was admitted to the facility in 2004. stored/charged in back hall Diagnoses for R63 included end stage dementia storage rooms on each nursing with a mood disorder, CVA (stroke) and unit floor (2<sup>rd</sup> and 3<sup>rd</sup> floors). blindness. Administrator had storage rooms

modified to accommodate electric wheelchair storage and charging

DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES			FORM APPROV	.UU2
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	4 - E - E - E - E - E - E - E - E - E -	<u> </u>	OMB NO. 0938-0	75L 391
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	y Connection	DENTI ICATION NUMBER.	Á. BUILDI	NG	COMPLETED	
		085012	B. WING_		07/25/2009	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD	E	
REGENO	Y HEALTHCARE & R	EHAB CENTER		801 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLET	
	An annual MDS (m dated 2/28/09, and stated that R63 had with short and long-R63 was totally depbed mobility (how relying position, turns body while in bed) physical assistance mechanical lift with Review of R63's ca 3/2/09 and last updates and last updates and last updates and last updates and last updates and last updates" Approximately appropriate and last updates and last	inimum data set) assessment, quarterly MDS, dated 5/29/09, I severe cognitive impairment term memory impairment endent on staff for all care, esident moves to and from side to side, and positions required 2+ persons for and she required a 2 persons for transfers.  The plan for side rails, dated ated 7/16/09, stated, "1. sted to use a side rail 2 1/2 ity/an enabler to promote actively participate in his/her aches included, "1. Patient Side Rail Consent Form 3. ducation on the safe use of traging use of alternative hysical therapy)/ O.T. by) screen/eval (evaluation) of side rails/alternative (09, the facility added rails) for safety, resident hits red." R63's high risk for falls 4/08, last updated on 7/16/09, " 26. padded SRs for	F 323		ill update der's foring of per storage g unit e Manager re entation sed on versus eaders will age and	
-	finger) Resident at r	sk for further fx's secondary Approaches included, " 12.				٠
į.	the state of the s	· •	. 1		9	

Review of a facility incident report and

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	: 10/09/2009 APPROVED
STATEMEN	T OF DEFICIENCIES		11				0938-0391
AND PLAN (	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION 3	(X3) DATE S COMPLE	
		085012	B. WIN	G		07/2	5/2009
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
REGENO	Y HEALTHCARE & R	EHAB CENTER		80	O1 N. BROOM STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	X,	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JÚĎ BE	(X5) COMPLETION DATE
F 323	Continued From page	ne 40	. F 3	93		<del></del>	
	investigation, dated resident's daughter them R63's right pin	4/24/09, stated that the came to staff at 8 PM and told ky finger was swollen and x-ray, dated 4/23/09, stated,	F 3	۷٥			
	" fracture 5th pro mild displacement. swelling. Impression	px-ray, dated 4/25/09, stated, oximal phalangeal base with There is associated soft tissue at the control oxide with increased risk for fx)	•				
	related right 5th fing	er fracture as described."  s note, dated 4/30/09, stated,		-			
,	trauma/fall reported	ie to severe osteoporosis- no reported in Nursing Home".				· · · · · · · · · · · · · · · · · · ·	
	plan, revealed no reassessments from 8	Il record, including the care cent falls or fx's. MDS /30/08 through 8/28/09 Inoses of osteoporosis or					
	pathological bone fx exception to this was	s and falls or other fx's. An					
	stated that R63 had days". R63's pain/or developed on 4/24/0	"other fracture in last 180 steoporosis care plan, 9, stated that R63's finger fx although subsequent					
`.	quarterly MDS asses	a diagnosis of pathological					
	During an interview v 7/23/09, she stated t						
=	sheets wrapped arou that R63's daughter (	cility in 1/09, she found and R63's SRs. She believed did it to protect the residents she implemented the					
	bolsters at this time, reflected it was done an interview on 7/21/	although the care plan later. E4 previously stated in 09 that R63's finger fx					
(	occurred after flailing	her hand against the		-		:	

		AND HUMAN SERVICES  & MEDICAID SERVICES			FORM	10/09/2009 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	(X3) DATE S COMPLI	URVEY
• .		085012	B. WING_	: 	07/2	5/2009
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
REGENO	CY HEALTHCARE & R	EHAB CENTER		301 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	Continued From page	ge 41	F 323			
		n 7/23/09, E4 clarified that it R63 hit her finger on the				
		.i.ee				
	to R63) was intervie bolsters were initiate	ertified Nurses Aide assigned wed. She confirmed that the ed in 1/09 and stated that prior				
	because R63 was c	I towels around the SR's ombative and hit the rails. nat although the bolsters are				
	attached by 4 velore remove them and E	straps each, R63 could 17 had found them on the				
		it staff put the bolsters back hat R63 continued to hit her side rails.				
	revealed R63 lying of bilateral SR's up and not observed attempt using the side rails a	s from 7/20/09 to 7/24/09 on her back in bed with full d bolsters in place. R63 was bring to reposition herself or as enablers. She did not				
	R63's ADL (activities dated 7/24/08 and la intervention, dated 9 requests resident be	of the rails. According to s of daily living) care plan, ast updated on 3/2/09, an 1/5/08, stated, "Family back in bed by 1600 (4 PM) x. 2-3 hours daily." R63				
		ly 21-22 hours per day in				
	stated that the family few years ago, but R them as enablers for	view on 7/23/09, R63's POA requested the side rails a t63 had not been able to use a "long time." The POA ned a consent for the rails.			• •	
"	revealed that R63 di	s on 3/3/09 and 6/2/09 d not have a history of falls, nedical condition that required				

DEPAR	RTMENT OF HEALTH	I AND HUMAN SERVICES				PRINTED	: 10/09/2009 APPROVED	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391	
STATEMEN AND PLAN	NT OF DEFICIÊNCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE S COMPLI	URVEY	
	-	085012	B. Win	NG_		07/2	07/25/2009	
NAME OF	PROVIDER OR SUPPLIER			СТ	REET ADDRESS, CITY, STATE, ZIP CODE		012000	
REGEN	CY HEALTHCARE & R	EHAB CENTER		٤	801 N. BROOM STREET WILMINGTON, DE 19806			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE -	
					DEFICIENCY)			
F 323	Continued From pa	ge 42	F.3	323	3			
		they indicated or served as				2		
· .	enablers to promote	independence						
		macpondeneo.					"	
	Record review reve	aled lack of a signed consent				*	. 1	
• "	for the side rails and	lack of any PT or OT				-		
	assessments or eva	aluations regarding the						
	appropriate use of s	side rails/alternative devices		٠,				
	as per the care plan	. These findings were		17		, , , , , ,		
	confirmed during int	erviews with E2 (Director of		٠				
	Nursing) on 7/22/09	and 7/23/09.						
	R63 had a history of	f hitting the side rails when						
	agitated, repetitive a	rm movements, resistance to						
	care, and removing	the bolsters placed on the						
	inside of the bed in	front of the side rails. The						
4	facility assessed in 3	3/09 and 6/09 that the side						
	rails were no longer	indicated and they no longer		- '				
4	served as enablers	to promote R63's						
	independence. The	facility failed to have a signed		. '				
	consent for usage o	f the side rails and they failed						
ŧ ,	to have PT/OT scree	enings and/or evaluations to						
: '	determine the appro	priateness of the						
		ces. R63 sustained a finger					-	
		9, which was thought to be		- 1				
.'	The facility care plan	g the bolster and/or side rail. nned R63 to be at risk for				48.00		
	further fy's due to co	mbativeness, yet they failed				4.5		
	to-recognize her side	rails as an accident hazard	· .					
	and this they remai	ned in place as of 7/24/09.						
	2 Resident electric	wheel chairs were observed						
	being charged in the	hallways on both the second		i				
	and third floors. Flee	ctric Wheel chairs must be						
		ea approved by the fire		ĺ			-	
	marshal.		٠	-				
F 325	483.25(i) NUTRITIO	N	F 32	25				
SS=D								
55.5	Based on a resident'	s comprehensive	*.*	1		ĺ		
ļ		lity must ensure that a		1				
	resident -	, and a supplied the supplied to the supplied	• '					

		AND HUMAN SERVICES			FORM APPROVED
	T OF DEFICIENCIES	& MEDICAID SERVICES	· 1		OMB NO. 0938-0391
AND PLAN (	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONST A. BUILDING	RUCTION	(X3) DATE SURVEY COMPLETED
	· .	085012	B. WING		07/25/2009
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE, ZIP CODI	·
REGENO	Y HEALTHCARE & R	EHAB CENTER	801 N. BRO	OM STREET ON, DE 19806	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EA	PROVIDER'S PLAN OF CORR CH CORRECTIVE ACTION S SS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 325	Continued From pa	ge 43	F 325 F325		
	(1) Maintains accep status, such as bod unless the resident's demonstrates that t	table parameters of nutritional y weight and protein levels, s clinical condition his is not possible, and apeutic diet when there is a	1.	Resident #84 will has supplements docum MAR as well as sand Preferences were up Resident will have with checked weekly by I discussed at weekly	ented on / / ' dwiches. odated. reights RD and
	•			meeting. Resident v	
				by Food Service Dire	
	by: Based on record revolutions it was failed to identify a seresident (R 84) out or residents. While the loss R 84, who was facility failed to docusustained a 7.8 % w facility failed to followat high risk for weighthe resident regardinand failed to ensure received the snacks also failed to addressone of the resident's	inew, interviews and determined that the facility evere weight loss for one of 37 stage II sampled edictician documented weight at risk for weight loss, the ment that the resident eight loss in 3 months. The with the care plan for a resident of the consumption of snacks the resident consistently as ordered. The care plan is the relationship between medical conditions Chronic ary Disease(COPD) and his		ensure that he is recorrect food items. All residents that are will be reviewed by the check on discharge weights. MD will be weight change is 5 pagreater. These reside reviewed at the homeeting. MAR's will for supplement or so that need document by the dietician. The Dietician will assess/reassess ear admission/read	e readmitted, the dietician to and readmit notified if bounds or dents will then high risk be checked hack orders ation on MAR  ch ion in a timely ian will be supplements and riately. The
	which included hype emphysema and car physician's history a diagnosis of brain ar Review of the Minim revealed 4 periods o	on 2/17/2009 with diagnosis rtension, schizophrenia, ncer. On the 7/20/2009 the nd physical included the reurysm, anxiety and pain. um Data Set (MDS) for R 84 f discharge and reentry to the e dates were 4/15/2009,	4.	recommendations for supplements/snacks	or s. High Risk weekly ng. The w the admission

accuracy.

		AND HUMAN SERVICES		-		FORM	:T070972009 APPROVED
	T OF DEFICIENCIES	& MEDICAID SERVICES	1			1	0938-0391
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		TPLE CONSTRUCTION NG	(X3) DATE S COMPLE	
		085012	B. Wil	NG_		07/2	5/2009
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
REGENO	CY HEALTHCARE & R	EHAB CENTER	· <u>.</u>	i	801 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325	Continued From pa	ge 44	F	325			
		99 and 7/12/2009. There was	. ' `	J <u>Z</u> U			
	also a significant ch	ange MDS completed on				-	
	6/4/2009.						
	The facility develop	ed a care plan for alteration in					
	nutrition and hydrati	on dated 2/20/2009 and					
	revised on 6/28/200	9 and 7/24/2009. This					
	included a goal of n	o significant weight loss					
	through next review 145 pounds. The ap	, and weight to remain above					
		ered, med pass 4 ounce three					
		nces obtained, sandwiches					
	as ordered and doci	ument on MAR. Under					
		ian wrote on 7/24/2009 weight		٠			
	care plan identified	monitor at high risk. While the periods when the resident lost					
.		entify the 7.8% weight loss in	*			•••	
	3 months. Additiona	lly the complete care plan					
	failed to mention or	identify the resident's	17			*	
	R84's caloric require	and how that would impact on					
	1.043 calonic require	sinents.					
	Review of R 84 weig	phts revealed the following:					
	2/24/2009 =159 pou	nds		-			~ .'
	4/27/2009=140 pour 5/5/2009 =140 pour		.=				
.	5/13/2009=139 pour		-		-	1.	
	5/20/2009=138 pour		:				
	6/28/2009=132.6 po						
	7/22/2009=129 pour	nds					
	severe weight loss in	nds, which represents a 7.8%					
		i a o month period.		:			
	<u>.</u>			. :			
-	Review of the nutriti	on progress notes dated		:			
	resumed to above 74	ident's oral intake had 5%. Resource (supplement)			,		ĺ
	needs to resume at	120 cc four times a day. At	,	j			
		t requested 2 sandwiches		1		į	
				1		:	. 1

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	: 10/09/2009   APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		TPLE CONSTRUCTION	(X3) DATE S COMPLI	
	,	085012	B. Wil			07/2	5/2009
NAME OF	PROVIDER OR SUPPLIER		<del></del>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 0112	.012000
REGENO	CY HEALTHCARE & R	EHAB CENTER		8	801 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	lΧ	PROVIDER'S PLAN OF CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 325	Continued From page	gė 45	F:	325			
F 325	and 2 sodas everyd requisition was com snack to be nightly a physician's order da resource 120 ml 3 ti cheese sandwiches snack. The physicia stated 2 Ham & Cheevery night.  The admission nurs 7/18/2009 stated the pounds. The next dietary profollowing: 7/20/2009 resident v Tuesday(7/21/2009) 7/21/2009 sent to E pains in stomach, wi 7/24/2009 see nutrii note.	ay for a bedtime snack. A diet pleted requesting this bedtime and routine. Additionally a ted 6/28/2009 stated resume mes a day and 2 Ham and and 2 sodas daily for HS norder sheet for 7/09 also sees sandwiches & 2 sodas and assessment dated a resident's weight as 130 gress notes stated the isited and will assess on R on 3-11. Resident had if re-eval upon his return, ion assessment for readmit		325			
	84's weight as now a resumed sandwiche discussion with the sandwiches would be more closely monitor						
	revealed orders are rand snacks until afte Therefore a resident possibly not receive:	as of 4/27/2009 and otal of 26 pounds by with facility staff (E2) not obtained for supplements an assessment by E8. at risk for weight loss could snacks and or supplements time dietician on her next					
						!	

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES			FORM	: 10/09/2009 APPROVED : 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE S	URVEY
		085012	B. WING	3	07/2	5/2009
NAME OF	PROVIDER OR SUPPLIER		[5	STREET ADDRESS, CITY, STATE, ZIP COD	<del></del>	
REGEN	CY HEALTHCARE & R	EHAB CENTER		801 N. BROOM STREET WILMINGTON, DE 19806		· .
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID . PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 325	Continued From pa	ge 46	F 32	25		
	The facility policy er Planning Process # significant weight lo physician, dietary, F and administration f 48 hours. Another f (between meal and Check tray before s is the correct diet or Review of the weigh 7/22/2009 revealed dropped to 129 pour 6/28/2009. Weight on 7/23/2009 by the been done. During a responsible for weigh	ntitled Nutritional Care 9 stated Those who fall within ss range are reported to the NAC, nursing administration or interventions within 24 to acility policy entitled Snacks bedtime) Serving stated in #2 erving snack to be sure that it dered	F 32	25		
	today. CNA returned 84's reweigh was 12	at 3:15 PM and stated R				
	7/23/2009 also confi not reordered or res returned on a weeke recorded. Interview of AM revealed she wa	nit manager) at 1:50 PM on rmed that resource was not umed after 6/28/2009. R 84 and and resource was not with E5 on 7/24/2009 at 9:45 s not aware of the reweigh at ED (E 30) and the MD were				
	10:30 AM on 07/23/2 supplement was not is not currently receive 7/18/09 listed a sand	on the MAR and the resident ving same. MD orders of				
	confirmed that she d	d not notify the MD or the				

DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES	6 9		of the first of the second second second		10/09/2009
		& MEDICAID SERVICES					APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE SI COMPLE	URVEY
		085012	ė. Wii	VG _		07/2	5/2009
NAME OF F	PROVIDER OR SUPPLIER		<del>- • · · ·</del>	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
REGENO	Y HEALTHCARE & R	EHAB CENTER		80	01 N. BROOM STREET VILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 325	Continued From pa	ge 47	F.	325		<del>- i ii - ,i;</del>	
	RD of decrease in v interview with (the r that since 7/18/2009 was not on the MAF	veight 7/24/2009 10:30 AM ned nurse) E 30 confirmed 9 the snack of 2 sandwiches R therefore the facility was ne resident's consumption.		323			
	stated that the weig resident being hosp that the snacks wer	with the with RD (E 8) she ht loss was due to the italized. She was not aware e not on the MAR, she plans ement and the snacks will be					
	at 8:03 PM on 7/23/ not 2 sandwiches at During an interview only received one sa was not checked pri resident for contents	revealed the resident in bed 2009. R 84 had received one and a bag of chips and 2 sodas with the resident he stated he andwich. Apparently the tray for to it being served to the s. R84 said I guess it is good e. He ate the chips and the					
	for R 84 by docume sustained a 7.8 % w to follow the care pla for weight loss and f	identify a severe weight loss nting when the resident reight loss in 3 months, failed an for a resident at high risk failed to monitor the resident mption of snacks and					
F 329 SS=D	483.25(I) UNNECES Each resident's drug unnecessary drugs. drug when used in e duplicate therapy); o without adequate mo	An unnecessary drug is any excessive dose (including or for excessive duration; or enitoring; or without adequate	F3	329			
		e; or in the presence of ces which indicate the dose		i			

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES						10/09/2009
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES						APPROVED
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(۷2) 1	41 /3 TC	IDLE CONO	TOUCTION		<u>0938-0391</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1 .			TRUCTION	(X3) DATE SU COMPLE	
			A. BU	ILDIN	1G	· · · · · · · · · · · · · · · · · · ·	00,000	120
		005040	B. WII	٧G		•		
		085012					07/25	5/2009
NAME OF I	PROVIDER OR SUPPLIER		"	STE	REET ADDR	RESS, CITY, STATE, ZIP CODE		
REGEN	CY HEALTHCARE & R	EHAR CENTED		8	01 N. BRC	OOM STREET	•	, <del>1</del>
	·	LIIAB CENTER		Ιv	VILMING	TON, DE 19806		-
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	- CI	-		PROVIDER'S PLAN OF CORRE	CTION	<del></del>
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	İΧ		ACH CORRECTIVE ACTION SE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CRO	SS-REFERENCED TO THE AP	PROPRIATE	DATE
		<u></u>		 	li da de la composición della composición della	DEFICIENCY)		
F 329	Continued From page	ne 48	Ė	329	1 1 - 1			1. 1.
	1.	or discontinued, or any		223		•		10/1/09
	combinations of the	reasons shows			F329	(DO4)		1, 1, 1
	Combinations of the	reasons above.			1.	R63 and R61's care p		
	Based on a compre	والغرا فوالوالية والأوالية والمراجعة	1		1.5	amended for psychotro	opic use.	
	resident the facility	nensive assessment of a	1		1	R91: MD wrote physic	ian's order	
	who have not used	must ensure that residents			i	for pharmacy indicatin	g alagnosis	
	given these drugs u	antipsychotic drugs are not	1 .			for medication.		, ,
	thorany is passes	nless antipsychotic drug	ľ		2.	All residents have the		
1 1	os disapped and d	to treat a specific condition				be affected by the def	icient	
	record: and regident	ocumented in the clinical				practice.		
	druge receive area	s who use antipsychotic		. 1	3.		ended as	1
	hobavioral intercent	al dose reductions, and				needed. Behavior she		
	penavioral interventi	ons, unless clinically				obtained and placed of		
		n effort to discontinue these				MAR's. Additional co		(
	drugs.					action includes the MI		
	e e e e e e e e e e e e e e e e e e e					responsible for assuri		
						resident medications		
						appropriate diagnosis	. The	
	e e			.		admitting MD will revi	ew	1 1
	This DEOLIDEMEN	T is not met as evidenced				residents' POS each		1
	by:	i is not met as evidenced			i	ensure all resident me		
		iew and interview, it was				have appropriate corr	esponding	
	determined that the	facility failed to have 2 (R63				diagnosis. The MD w	ill write in	
	and P01) campled in	esidents' drug regimens free	1 1			appropriate diagnosis		
	from unnecessary de	ugs. The facility failed to				medication found to n		1
	monitor for behavior	s and side effects related to		.		appropriate correspon	naing	-
	the antinevelotic ma	dication Seroguel and the				diagnosis. DON will o	obtain a	
	antianxiety medication					weekly psychotropic	report from	
		ity failed to list and document				pharmacy to update of	onto care	-
	lesser alternatives (n	on-drug interventions) before		į		plans by RNAC		
	administering Ativon	and they to failed to perform			4.		il be stored	1
	an AIMS (Abnormal)	nvoluntary Movement Scale)	<u> </u> 			in a POS binder until		
7 -	test when R63 was a	tarted on Seroquel. The		!		the admitting MD. Ea	acn admitting	
	facility failed to docur	nent an approprieto		.		MD will review and m		
	diagnosis for P01's	rilosec (for heartburn); the		i		POS binder for reside		
		equently discontinued.				medications and app		1
	Findings include:	equently discontinued.				corresponding diagno	osis.	
Ì	i maniga moluue.			.			. 1	^
	1. Diagnoses for R63	included and stage		;			- !	,
	Diagnoses for Noc	moranen erin stade		İ		* *	1	

DEPAR CENTE	TMENT OF HEALTH RS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 10/09/2009 M APPROVED D: 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION	(X3) DATE COMPI	SURVEY
	· .	085012	B, WING	<u> </u>	77/	25/2009
	PROVIDER OR SUPPLIER	EHAB CENTER	S	BTREET ADDRESS, CITY, STATE, ZIF 801 N. BROOM STREET WILMINGTON, DE 19806		29/2009
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
. 1	The 7/09 POS (physthat R63 had Seroq twice a day and Ativ hours as needed for ordered on 5/26/09.  Care plans were depotential for psychological for psychol	od disorder and blindness. sician order sheet) revealed uel (antipsychotic) 25 mg ran (antianxiety) 1 mg every 6 ragitation/aggression that was veloped on 6/1/09 for the tropic drug-related side effects ipsychotic and anxiolytic tions. Approaches listed on ed, "1 monitor for de effects of medication 4. ent signs/symptoms of vell as positive effects from ciolytic care plan also listed explore ways to eliminate" and R63's antipsychotic ntervention " AIMS testing		<u> </u>		
	The facility failed to I side effects (includin medications, they fai going to monitor for of the medications. I document approache for R63, and failed to	ist and document specific g behaviors) related to the lled to identify how they were effectiveness and side effects hey failed to identify and es in which to reduce anxiety o list lesser, non-drug ement before administering				
6   5   C   L   A	and E22 (Medication stated that the only produced were only or Certified Nurses Antivan medication ad Additionally, interview	med with E4 (Unit Manager) Nurse) on 7/23/09. E4 lace behaviors were ADL flow sheets (completed lides) and on the back of the ministration record. S with E2 (Director of firmed that the facility failed				

DEPAR	TMENT OF HEALTH	I AND HUMAN SERVICES				PRINTED	: 10/09/2009
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	-2			FORM OMB NO	APPROVED 0938-0391
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE S COMPLI	URVEY
		085012	B. Wil	NG _		07/2	5/2009
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
REGEN	CY HEALTHCARE & R	EHAB CENTER		.8	01 N. BROOM STREET VILMINGTON, DE 19806		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE OPRIATE	(X5) COMPLETION DATE
F 329	Continued From page	ge 50	F;	329			
	to perform an AIMS	(Abnormal Involuntary					
		est when Seroquel was started					
	on 5/26/09. They sta	ated it was facility practice					
	(confirmed in review	v of the facility AIMS testing				•	·
	policy) to do it 6 mo	nths after an antipsychotic				•	. ]
	was started and eve	ery 6 months thereafter,				• .	
	although the policy	stated, "Tardive dyskinesia					
	(ID) is a syndrome	characterized by abnormal					
	mouth trunk or limit	ents of the patient's face,					
		bs which affects 20%-30% of patients TD can develop					
		month". The facility failed to	l i				1
."		IS test when R63's Seroquel					
	was started on 5/26	/09 so that a comparison		i			
		onths later to monitor for any					
	changes.						
	2. Review of R91's 7	7/09 POS (Physician's Order	.**				
t.	Sheet) revealed and	order, dated 1/1/09, "Prilosec					[
*		twice daily before meals."					
		al record lacked evidence of a	i	. :			
	diagnosis or an adec	quate indication for its use.		*			
	During an interview,	E4, the unit manager,				. "	
	confirmed this findin	g after obtaining a physician's		ļ		•	
	order, dated 7/23/09	ec OTC (Over The Counter)."					
F 364	483.35(d)(1)-(2) FO		F3	61			
SS=E	+00.00(a)(1)-(2)1 O	JD	ĘŶ	104			
33-1	Each resident receiv	es and the facility provides					
ĺ	food prepared by me	ethods that conserve nutritive	1	.		ē .	
-	value, flavor, and ap	pearance; and food that is				٠.	
	palatable, attractive,			ļ			
	temperature.						
	-						
	TI DESIMA						
		T is not met as evidenced		-			
	by:			i		-	
		ns and resident interviews it	-	. !		•	
	was determined that food that was palatat	the facility failed to serve		. '			

		AND HUMAN SERVICES		1 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (	PRINTED: 10/09/2009 FORM APPROVED
		& MEDICAID SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BÜİLDI	TPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		085012	B. WING_		07/25/2009
NAMEOF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP COD	
REGENO	Y HEALTHCARE & R	EHAB CENTER	3	801 N. BROOM STREET WILMINGTON, DE 19806	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION (X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
F 364	Continued From pa	ae 51	F 364		iol at
	acceptable tempera R41, R27, R36, R66	eture. Six residents (R13, 5 and R39) complained about ays confirmed that the food	r 304	F364 1. Food Service Dire with R13, R41, R2	ctor will meet 7, R36, R66,
	7/21/09, R13, R41, stated that the food served at the prope 2. On 7/23/09, trays floor at 5:09 PM. At was delivered, the troor temperature and R13's tray included degrees F, apple jui	for dinner arrived on the 2nd 5:28 PM when the last tray est tray for R13 was evaluated palatability. Temperatures on lasagna with marinara 124.5 ce 71 degrees F, and milk		and R39 to determin resident specific interesident specific interesident specific interesident staff will be in Food Service Director temperatures and partices and partices.  3. Weekly test trays with completed by the FS Staff will be in-service food. Test tray resuresident specific in the Staff will be in-serviced.	rvention. n-serviced by or on food alatability. e potential to eficient Il be SD and RD. ced on safe
	which was lukewarn and the apple juice was determined to the 3. On 7/23/09, trays floor at 5:20 PM. At was delivered to a refor R41 was then ever palatability. Temperature soup of the day 129 marinara 122.7 degrees F, fruit cock cranberry juice 73.2	for dinner arrived on the 3rd 5:42 PM when the last tray esident's room, the test tray aluated for temperature and atures on R41's tray included degrees F, lasagna with ees F, green beans 114		tracked weekly and Operational Scoreca 4. Corrective actions we monitored by the Formation through Of Scorecard which will trays, tray audits, resulting satisfaction surveys service temperature Food Service Direct findings at facility Quantum control of the satisfaction for the satisfaction surveys service temperature food Service Direct findings at facility Quantum control of the satisfaction surveys service temperature food Service Direct findings at facility Quantum control of the satisfaction surveys service temperature food Service Direct findings at facility Quantum control of the satisfaction surveys service temperature food Service Direct findings at facility Quantum control of the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service temperature for the satisfaction surveys service	posted in ard.  Ill be od Service perational include test sident and pre- results.  Torwill present
	soup and the lasagn green beans were m	a which were lukewarm, the lushy and cool, and the lea water were warm. The			
	chair with her dinner front of her. R39 sta	tray on the bedside table in ted that the food was			

CEN.	TERS FOR MEDICARE	AND HUMAN SERVICES  MEDICAID SERVICES				FORM	: 10/09/2009 I APPROVED : 0938-0391
STATEM	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE (	CONSTRUCTION	(X3) DATE S COMPLI	URVEY
		085012	B. WIN	ıG		07/2	25/2009
NAME C	F PROVIDER OR SUPPLIER	= .		STREET	ADDRESS, CITÝ, STATE, ZIP CO		.0.200
REGE	NCY HEALTHCARE & R	EHAB CENTER		801 N.	BROOM STREET INGTON, DE 19806		
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 36	Continued From pa meal.	ge 52	F3	64			
	Additionally, on 7/20 that the ice machine kitchen.	0/09 an observation was made was not working in the					
F 37	palatable and at the 7/24/09, findings we Regional Dietary Ma Director.	provide food that was proper temperature. On the acknowledged by E12 anager, and E13 Food Service					
\$S=	The facility must - (1) Procure food from considered satisfact authorities; and	m sources approved or or local listribute and serve food	F.3		<ul><li>371</li><li>1. Corrective action sanitary condition</li><li>preparation will be an dietary/kitchen staff in</li></ul>	s of food	10/15/09
	This PEOLUDEMEN	T is not met as evidenced			through HACCP. Foo been delivered and di were in the processes put away. Dented car	od had just etary staff s of being ns were	
-	by: Based on observation dietary area, it was difailed to store, prepa	ns and interviews in the letermined that the facility re, distribute, and serve food tions. Findings include:			removed and discarded. All residents have the be affected by the definition practice.  Staff will be in-service Service Director on seconditions of food pre-	potential to ficient ed by Food anitary	
	9:20 AM, a pan of from bags) tabled for Wed being thawed at room Interview with E13, the confirmed that the from the state of the state	the kitchen on 7/20/09 at ozen chicken (in two large inesday lunch was observed in temperature on a counter. The dietary manager, ozen chicken should not have soom temperature and it is		4	be completed by Sept 2009. Food to be put promptly and appropr delivered. Compliance will be tra monitored through mo service logs to be ma the Food Service Dire	away iately when acked and onthly in- intained by	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		·		PRINTED FORM	10/09/2009 APPROVED
		& MEDICAID SERVICES					0938-0391
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		DISTRUCTION	(X3) DATE S COMPL	
		085012	B. WINC	3		07/3	25/2009
NAME OF	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		0,200
REGEN	CY HEALTHCARE & R	EHAB CENTER		801 N. E	BROOM STREET NGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX		PROVIDER'S PLAN OF CORRE	IOULD BE	(X5) COMPLETION DATE
.,		SO IS ENTIL THIS INTO CHARACTER)	TAG		CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	DATE
F 371	Continued From pa	ge 53	F 37	71			
		v frozen food products in the				•	
a c		f the kitchen on 7/20/09 at				•	
·	9:20 AM, at least 3	large cans (kidney beans, vere observed dented at the					
F 411	crease in the food s	torage area.					9/30/09
SS=D	483.55(a) DENTAL		F 41	7  F41	1		Marlod
	The facility must as routine and 24-hour	sist residents in obtaining emergency dental care.			<ol> <li>Social Service Director contact R13's legal File</li> </ol>	r has nancial POA	<b>\</b>
		de or obtain from an outside ance with §483.75(h) of this			and requested financial information to qualify res	ident for	
	part, routine and em	ergency dental services to ach resident; may charge a			Nemours certification in	order to	
	Medicare resident a	n additional amount for	<u> </u>		obtain dental services in fitting and new dentures.	cluding Social	
	routine and emerge necessary, assist th	ncy dental services; must if e resident in making			Service Director is await financial information, not	ing	
	appointments; and b	by arranging for transportation			received as of 9/1/09. S	ocial	
	residents with lost o	ist's office; and promptly refer r damaged dentures to a			Service Director will make follow up phone call to re		
	dentist.				Financial POA of the need financial information.		
		To be a character of a constitute way of		2.	All residents have the po	tential to	
	by:	T is not met as evidenced			be affected by the deficie practice.	ent .	
		ons, interviews and record	J	3.	Social Service Director d		·
	resident (R13) did no	ot receive necessary dental	-		a Sensory Assessment to done upon	o be	
	services in a timely r	nanner. Findings include:	٠.,		admission/readmission a		
		the facility on 3/6/09 with			quarterly thereafter to tra hearing, and dental need	is and	
	diagnoses that include				follow up on scheduled appointments, done by n		
	Observations of R13	throughout the survey from /09, revealed that he had		4.	Corrective action will be	-	
	some bottom teeth a	nd no top teeth. Top	-	÷	monitored at resident qua		
		ved on his bedside table	* .	i	care conferences and QI	,	

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/09/2009 APPROVED : 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		085012	B. WII	۷G		07/2	5/2009
	PROVIDER OR SUPPLIER  CY HEALTHCARE & R	EHAB CENTER	•	8	REET ADDRESS, CITY, STATE, ZIP CODE 301 N. BROOM STREET WILMINGTON, DE 19806		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ļΧ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 411	Continued From page	ge 54	F4	411			
	stated that his top d	on 7/21/09 at 9:00 AM, R13 entures did not fit anymore able to chew everything.					Professional
	only oral assessment upon admission white had his own teeth or dentures. Care plant indicated the same.	nical record revealed that the not that he had was on 3/6/09 ch stated that the resident on the bottom and upper as for "Dental" and "ADL's"  There was no evidence that R13's ill-fitting top dentures.					
	7/23/09, revealed the done upon admission	, the unit manager, on lat oral assessments were n and then again only if a e Alde) reported a problem.		-			
	worker, on 7/23/09, were identified as ne stated that nursing rand she would arran stated that all reside dental care. Since F months ago, he wou services until he had	with E9, the facility's social when asked how residents eding dental services, she eported the problem to her ge for dental care. She nts are provided with yearly R13 was only admitted four ld not be scheduled for dental been in the facility for close here was an immediate need					
	R13 which resulted in resident had a history	provide dental services for n chewing problems. This y of weight loss, yet staff was ill-fitting top dentures and					
	missing bottom teeth him to eat all foods.	which made it difficult for Findings were acknowledged ion at the informational		-			



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<sup>†</sup> DHSS - DLTCRP 3 Mill Road, Suite 308 Wilmington, Delaware 19806 (302) 577-6661

STATE SURVEY REPORT

LT C Residents Protection

DATE SURVEY COMPLETED: July 25, 2009

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NAME OF FACILITY: Regency Healthcare and Rehab Center

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED STATEMENT OF DEFICIENCIES Specific Deficiencies SECTION

•		· ——,-,-,-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			-
				3201.6.1.1 What corrective action(s)will be taken to ensure compliance with 3201.6.1.1:  Cross refer to CMS 2567-L survey date completed 7/25/2009, F311, F312, F313, F318, F323, F325, F329(1)	
. 1				npliar pletec 325.	
•				e cor com <sub>l</sub> 23. F	-
				ensur date 8. F3	•
				en to urvey	•
		•	٠.	e take 7-L s F313	
				corrective action(s)will be taken to ensure compliant to the solution of the complete of the complete completed to the complete completed 7/25/2009, F311, F312, F313, F318, F323, F325, F325, F312, F312, F318, F323, F325, F325, F312, F318, F318, F323, F325, F318, F318, F318, F318, F325, F325, F318, F318, F318, F325, F	
•				on(s) cCM8	1
	•			e actions ester to sfer to 59. F3	F364, and F411
:				1 rective 1; 5/20(	64, al
				3201.6.1.1 What corred 3201.6.1.1: • Cros	F.3
				3201 Wha 3201	
Revised state report after IDR of 9/30/09.	An unannounced QIS annual survey was conducted at this facility from July 20, 2009 through July 25, 2009. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 98. The survey sample totaled 107 residents, which	included 40 census residents, 30 admission residents and 37 stage 2 residents.  Nursing Home Regulations For Skilled and intermediate Care	General Services	The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.	This requirement is not met as evidenced by:
	·			3201.6.1.1	

Date

Provider's Signature



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#### STATE SURVEY REPORT

NAME OF FACILI	NAME OF FACILITY: Regency Healthcare and Rehab Center	DATE SURVEY COMPLETED: July 25, 2009
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross refer to CMS 2567-L, survey date completed 7/25/09, F311, F312, F313, F318, F323, F325, F329 (1), F364, and F411.	
3201.6.5	Nursing Administration	
3201. 6.5.6	A comprehensive care plan shall be developed to address medical, nursing, nutritional and psychosocial needs within 7 days of completion of the comprehensive assessment. Care plan development shall include the	<ul><li>3201.6.5.6</li><li>What corrective action(s) will be taken to ensure compliance with</li><li>3201.6.5.6:</li><li>Cross refer to the CMS 2567-L survey report date</li><li>completed 7/25/2009, F279.</li></ul>
	interdisciplinary team that includes the attending physician, an RN/LPN and other appropriate staff as determined by the resident's needs. With the resident's consent, the resident, the resident's family or the resident's legal representative may attend care plan meetings.	
	This requirement is not met as evidenced by:	
3201, 6.5.7	7/25/09, F279 The assessment and care plan for each	3201.6.5.7 What corrective action(s) will be taken to ensure compliance with 3201.6.5.7:
	resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A	• Cross refer to CIMS 2307-L survey date compressed 7/25/2009, F280.



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## NAME OF FACILITY: Regency Healthcare and Rehab Center

DATE SURVEY COMPLETED: July 25, 2009

		DAIL SONVET COMPLETED. July 43, 2003
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
10-71-70-01-1-1-1-1-1-1-1-1-1-1-1-1-1-1-		
-	conducted and a comprehensive assessment shall be	
	This requirement is not met as evidenced by:	
	Cross refer to CMS 2567-L, survey date completed 7/25/09, F280.	
3201. 6.5.8	This requirement is not met as evidenced by:	3201.6.5.8
	The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	What corrective action(s) will be taken to ensure compliance with 3201.6.5.8.  • Cross refer to CMS 2567-L survey date completed 7/25/2009, F221.
	Cross refer to CMS 2567-L, survey dated completed 7/25/09, F221.	
3201.6.5.8.2	The facility shall follow a comprehensive, systematic process of evaluation and care planning to ameliorate medical and psychosocial indicators prior to restraint use.	<ul><li>3201.6.5.8.2</li><li>What corrective action(s) will be taken to ensure compliance with 3201.6.5.8.2:</li><li>Cross refer to CMS 2567-L survey date completed</li></ul>
	Cross refer to CMS 2567-L, survey dated completed 7/25/09, F221.	7/25/2009, F221.



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### NAME OF FACILITY: Regency Healthcare and Rehab Center

DATE SURVEY COMPLETED: July 25, 2009	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
NAME OF FACILITY: Regency Healthcare and Rehab Center	SECTION STATEMENT OF DEFICIENCIES Specific Deficiencies

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.5.8.3	The resident's care plan shall document the facility's use of interventions, such as modifying the resident's environment to increase safety, and use of assistive devices to enhance monitoring in order to avoid the use of restraints.	<ul><li>3201.6.5.8.3</li><li>What corrective action(s) will be taken to ensure compliance with 3201.6.5.8.3.</li><li>Cross refer to CMS 2567-L survey date completed 7/25/2009, F221.</li></ul>
	Cross refer to CMS 2567-L, survey dated completed 7/25/09, F221.	
3201.6.5.8.6	When the use of restraints has been implemented, the facility shall initiate a systematic process, on an ongoing basis, documented in the care plan, in an effort to employ the least restrictive restraint.	What corrective action(s) will be taken to ensure compliance with 3201.6.5.8.6:  Cross refer to CMS 2567-L survey date completed 7/25/2009, F221.
	Cross refer to CMS 2567-L, survey dated completed 7/25/09, F221.	
3201.6.6	Activities	
3201.6.6.1	The nursing facility's activities program shall provide diversified individual activity plans and group activities for each resident based on the comprehensive assessment as well as an activity assessment conducted by the activity director. The activities offered shall reflect the	<ul><li>3201.6.6.1</li><li>What corrective action(s) will be taken to ensure compliance with 3201.6.6.1:</li><li>Cross refer to CMS 2567-L survey date completed 7/25/2009, F248.</li></ul>
,	needs, interests, abilities, preferences, limitations and age of each resident.	



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# NAME OF FACILITY: Regency Healthcare and Rehab Center

NAME OF FACILI	NAME OF FACILITY: Regency Healthcare and Rehab Center	DATE SURVEY COMPLETED: July 25, 2009
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross refer to CMS 2567-L, survey dated completed 7/25/09, F248.	
3201.6.7	Social Services	
3201.6.7.1	The facility shall identify each resident's need for social services to attain or maintain the highest practicable physical, mental and	
	psychosocial well-being of each resident; and shall assist each resident to obtain all required services to meet the individual resident's needs. These social services shall include, but	
	not be inflied to:	3201.6.7.1.1
3201.6.7.1.1	Making arrangements for obtaining needed adaptive equipment, clothing and personal items.	What corrective action(s) will be taken to ensure compliance with 3201.6.7.1.1:  • Cross refer to CMS 2567-L survey date completed 7/25/2009, F250.
	Cross refer to CMS 2567-L, survey dated completed 7/25/09, F250.	
3201.6.7.1.2	Making referrals and obtaining services from outside entities.	3201.6.7.1.2 What corrective action(s) will be taken to ensure compliance with 3201.6.7.1.2:  Cross refer to CMS 2567-L survey date completed
	completed 7/25/09, F250.	//ZD/Z003, T.Z50.
3.	Assisting residents to determine how they	



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DATE SURVEY COMPLETED: July 25, 2009

# STATE SURVEY REPORT

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What corrective action(s) will be taken to ensure compliance with What corrective action(s) will be taken to ensure compliance with What corrective action(s) will be taken to ensure compliance with ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED Cross refer to CMS 2567-L survey date completed 7/25/2009, F250. Cross refer to CMS 2567-L survey date completed Cross refer to CMS 2567-L survey date completed 7/25/2009, F329. 7/25/2009, F325. 3201.6.11.1.1: 3201.6.7.1.5: 3201.6.7.1.5 3201.6.11.1.1 3201.6.8.3.3: 3201,6.8.3.3 would like to make decisions about their health dated by the ordering physician or prescriber. anyone else to be involved in those decisions accordance with orders which are signed and counter) shall be administered to residents in The facility shall have an ongoing evaluation All medications (prescription and over-the-Each medication shall have a documented This requirement is not as evidenced by: care, and whether or not they would like Cross refer to CMS 2567-L, survey dated Cross refer to CMS 2567-L, survey dated and assessment program to meet the nutritional needs of all residents. STATEMENT OF DEFICIENCIES Specific Deficiencies Medication Administration completed 7/25/09, F250. **Nutritional Assessment** completed 7/25/09, F325. Food Service Medications 3201.6.11.1.1 3201.6.8.3.3 SECTION 3201.6.11.1 3201.6.8.3 3201.6.11 3201.6.8



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NAME OF FACILITY: Regency Healthcare and Rehab Center

DATE SURVEY COMPLETED: July 25, 2009

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	supporting diagnosis. Verbal or telephone orders shall be written by the nurse receiving the order and then signed by the ordering physician or prescriber within 10 days.	
	Cross refer to CMS 2567-L, survey dated completed 7/25/09, F329, example 2.	
3201.7.0	Plant, Equipment and Physical Environment	
3210.7.3	Facility Systems Requirements	•
3201.7.3.3	Facility lighting shall meet current standards of the Guidelines for Design and Construction of Health Care Facilities.	3201.7.3.3 What corrective action(s) will be taken to ensure compliance with 3201.7.3.3:
	Cross refer to CMS 2567-L, survey dated completed 7/25/09, F256.	<ul> <li>Cross refer to CMS 2567-L survey date completed 7/25/2009, F256.</li> </ul>
3201.7.5	Kitchen and Food Storage Areas	
3201.7.5.1	Facilities shall comply with the Delaware Food Code.	3201.7.5.1
	This requirement is not met as evidenced by:	What corrective action(s) will be taken to ensure compliance with 3201.7.5.1:
	Based on dietary observations on 3/23/2009, it was determined that the facility failed to comply with sections: 3-202.15 and 3-501.13 of	<ul> <li>(Ex 2) Cross refer to CMS 2567-L survey date completed 7/25/2009, F371.</li> </ul>



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## NAME OF FACILITY: Regency Healthcare and Rehab Center

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NAME OF FACILIE	NAIWE OF FACILITY: <u>Regency Healthcare and Renab Center</u>	DATE SURVET COMPLETED: July 23, 2003
SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	the Delaware Food Code. Findings include:	
	3-202.15 Package Integrity.*	3201.7.5.1 What corrective action(s) will be taken to ensure compliance with
	Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential	3201.7.5.1:  • (Ex 1) Cross refer to CMS 2567-L survey date completed 7/25/2009, F371.
	contaminants.	
	Cross refer to CMS 2567-L, survey date completed 7/25/09, F371, example 2.	
	3-501.13 Thawing.	
	Except as specified in ¶ (D) of this section, potentially hazardous food shall be thawed:	
-	(A) Under refrigeration that maintains the food temperature at 5°C (41°F) or less, or (B) Completely submerged under running water:	
	(1) At a temperature of 21°C (70°F) or below,	
1,01144	(2) With sufficient water velocity to agitate and float off loose particles in an overflow, and:	
	(4) For a period of time that does not allow thawed portions of a raw animal food requiring	



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STATE SURVEY REPORT

DATE SURVEY COMPLETED: July 25, 2009 NAME OF FACILITY: Regency Healthcare and Rehab Center

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	(B)		the  16 <u>Del. C.</u> , Subchapter II, SS 1121 What corrective action(s) will be taken to ensure compliance with 16 <u>Del. C.</u> , Subchapter II, SS 1121  • (Ex 1) Cross refer to CMS 2567-L survey date completed 7/25/2009, F241.
STATEMENT OF DEFICIENCIES Specific Deficiencies	cooking as specified under ¶ 3-401.11 (A) or (B) to be above 5°C (41°F) as specified under ¶3-501.16 (C) for more than 4 hours including:  (a) The time the food is exposed to the running water and the time needed for preparation for cooking, or	(b) The time it takes under refrigeration to lower the food temperature to 5°C (41°F) as specified under ¶ 3-501.16 (C); (C) As part of a cooking process:  Cross refer to CMS 2567-L, survey completed 7/25/09, F371 Example 1.	It is the intent of the General Assembly, and the purpose of this section, to promote the interests and well-being of the patients and residents in sanitoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interests of the patient shall be protected by a declaration of a patient's rights, and by requiring that all
SECTION			16 <u>Del. C.,</u> Subchapter II, § 1121

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DELAWARE HEALTH AND SOCIAL SERVICES

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NAME OF FACILITY: Regency Healthcare and Rehab Center

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH DATE SURVEY COMPLETED: July 25, 2009 ANTICIPATED DATES TO BE CORRECTED STATEMENT OF DEFICIENCIES Specific Deficiencies SECTION

such rights, which shall include but not be limited to the following:

right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.

Cross refer to CMS 2567-L, survey completed 7/25/09, F241.

and communicate, including visits and visitation, privately and without restriction with persons and groups of the patient's or resident's own choice (on the patient's or resident's own or their initiative) at any reasonable hour; may send and shall receive mail promptly and unopened; shall have access at any reasonable hour to a telephone where the patient may speak privately; and shall have access to writing instruments, stationery and postage. Nothing in 77 Del. Laws, c. 49 shall preclude a nursing facility or similar facility, as defined in § 1102(4) of this title, from restricting visitations due to attempts

(Ex 1) Cross refer to CMS 2567-L survey date completed 7/25/2009, F241.

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STATEMENT OF DEFICIENCIES  Specific Deficiencies  Specific Deficiencies  Specific Deficiencies  Specific Deficiencies  to interfere with patient care, the presentation of a threat to staff, patients and residents, or personnel, or other actions disruptive to the facility's operations.  This requirement is not met as evidenced by;  Cross refer to CMS 2567-L, survey completed 7/25/09, F174.  (25) Every patient and resident shall be free to make choices regarding activities, schedules, health care and other aspects of the patient's or resident's life that are significant to the patient or resident, as long as such choices are consistent with the patient's or resident's interests, assessments and plan of care and do not compromise the health or safety of the individual or other patients or residents within the facility.  This requirement is not met as evidenced by:  Cross refer to CMS 2567-L, survey completed 7/25/09, F242.  (26) Every patient and resident has the right to participate in an ongoing program of activities	TATE CANADA VINCENTIA	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH	1	tation S, or the	d by:	jea.	ree to • (Ex 11) Cross refer to CMS 2567-L survey date completed fulles, 7/25/2009, F174.  ent's ecs are	aild go ne Mithin Mithin	, p	3ht to (Ex 25) Cross refer to CMS 2567-L survey date completed vities
₩ 1 <del>4</del> 1	NAME OF FACILITY: Regency Healthcare and Rehab Center	SECTION STATEMENT OF DEFICIENCIES Specific Deficiencies	to interfere with mations	of a threat to staff, patients and residents, or personnel, or other actions disruptive to the facility's operations.	This requirement is not met as evidenced by:	Cross refer to CMS 2567-L, survey completed 7/25/09, F174.	(25) Every patient and resident shall be free to make choices regarding activities, schedules, health care and other aspects of the patient's or resident's life that are significant to the patient or resident, as long as such choices ar consistent with the patient's or resident's interests, assessments and plan of rare and all the patient of rare and plan of rare and all the patients.	not compromise the health or safety of the individual or other patients or residents within the facility.  This requirement is not met as evidenced by:	OMS 2567-L, sur	(26) Every patient and resident has the right to participate in an ongoing program of activities designed to most in the second to m



Division of Long Term Care Residents Protection

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STATE SURVEY REPORT

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH DATE SURVEY COMPLETED; July 25, 2009 ANTICIPATED DATES TO BE CORRECTED NAME OF FACILITY: Regency Healthcare and Rehab Center STATEMENT OF DEFICIENCIES Specific Deficiencles SECTION

patient's or resident's assessments and plan of care, the patient's or resident's interests and physical, mental and psychosocial well-being.

This requirement is not met as evidenced by:

Cross-refer to CMS 2567-L survey date completed 7/25/09, F248.

(28) Every patient and resident shall receive notice before the resident's room or roommate is changed, except in emergencies. The facility shall endeavor to honor the room or roommate requests of the resident whenever possible.

This requirement is not met as evidenced by:

Cross refer to CMS 2567-L, survey completed 7/25/09, F247.

 (Ex 26) Cross refer to CMS 2567-L survey date completed 7/25/2009, F248. (Ex 28) Cross refer to CMS 2567-L survey date completed 7/25/2009, F247.